NOTICES OF FINAL RULEMAKING

The Administrative Procedure Act requires the publication of the final rules of the state's agencies. Final rules are those which have appeared in the *Register* 1st as proposed rules and have been through the formal rulemaking process including approval by the Governor's Regulatory Review Council. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the *Arizona Administrative Register* after the final rules have been submitted for filing and publication.

NOTICE OF FINAL RULEMAKING

TITLE 4. COMMERCE, PROFESSIONS AND OCCUPATIONS

CHAPTER 39. STATE BOARD FOR PRIVATE POSTSECONDARY EDUCATION

PREAMBLE

1. **Sections Affected** — **Rulemaking Action**

R4-39-103	Amend
R4-39-104	Amend
R4-39-105	Amend
R4-39-106	Amend
R4-39-107	Amend

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statute: A.R.S. § 32-3003(A)(3)

   Implementing statutes: A.R.S. § 32-3003, 32-3021, 32-3022, 32-3025, 32-3026, 32-3027, 32-3051, and 32-3055.

3. **The effective date of the rules:**

   October 10, 1997

4. **A list of all previous notices appearing in the Register addressing the final rule:**

   Notice of Rulemaking Docket Opening: 2 A.A.R. 4437, November 1, 1996.

   Notice of Proposed Rulemaking: 3 A.A.R. 177, January 17, 1997.

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

   Name: Teri Candelaria, Executive Director

   Address: State Board for Private Postsecondary Education
   1400 West Washington, Room 260
   Phoenix, Arizona 85007

   Telephone: (602) 542-5709

   Fax: (602) 542-1253

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**

   The Board has amended 5 rules within Article 1 of the State Board for Private Postsecondary Education rules, in order to clarify the application content requirements for original licensure and annual license renewal. The amendments also clarify causes for disciplinary action, move the application content requirements for license renewal of an existing private non-accredited vocational institution from R4-39-105 to R4-39-104, delete the requirement that a new private non-accredited degree-granting institution have operated for 9 months prior to seeking licensure, and clarify requirements regarding accreditation and on-site visit procedures for private non-accredited degree-granting institutions in Arizona.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

   Not applicable.

8. **The summary of the economic, small business, and consumer impact:**

   Identification of the Proposed Rulemaking:

   R4-39-103, R4-39-104, R4-39-105, R4-39-106, and R4-39-107 were amended by the Board in keeping with the Board's 5-Year Rule Review Report accepted by the Governor's Regulatory Review Council on August 6, 1996. The rule amendments make technical and administrative changes to clarify licensure requirements already specified in licensure application materials and other Board materials.

Summary of Information Included in Statement:

The Economic, Small Business, and Consumer Impact Statement identifies that the rule amendments present neither additional costs nor benefits to the implementing agency, the persons and institutions subject to licensure by this Board, public or private employment in businesses directly affected by the proposed rules revisions, small business, private persons, or consumers. The Statement identifies that the Board is unaware of any other agencies or political subdivisions of this state directly affected by the implementation and enforcement of the proposed rulemaking.

The statement identifies that the administrative and other costs required of small business for compliance with the current rules will neither increase nor decrease as a result of the rule amendments and that the rule amendments will have no probable effect on state revenues, board revenues or the revenues or payroll expenditures of employers who are subject to the proposed rules amendments.

The statement identifies that the Board is not aware of any other less intrusive or less costly alternative methods of achieving the purpose of the rule amendments.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**
The Notice of Proposed Rulemaking did not include revision of R4-39-101, which had been included in the Notice of Rulemaking Docket Opening. The text of the adopted rules in the final rulemaking package has been modified from the text of the proposed rules in the Notice of Proposed Rulemaking to include statutory and rule references when applicable, to ensure that rule language is consistent among the rules and to ensure that rule language conforms to the required rule drafting style.

10. **A summary of the principal comments and the agency response to them:**
The Board did not receive any comments regarding the rulemaking.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
Not applicable.

12. **Incorporations by reference and their location in the rules:**
None.

13. **Was this rule previously adopted as an emergency rule?**
No.

14. **The full text of the rules follows:**

TITLE 4. COMMERCE, PROFESSIONS AND OCCUPATIONS

CHAPTER 39. STATE BOARD FOR PRIVATE POSTSECONDARY EDUCATION

ARTICLE 1. DEFINITIONS, LICENSURE, REPORTING

R4-39-103. Requirements for Regular Licensure to Operate ~~Operating~~ a Private, Accredited, Vocational or ~~and~~ Degree-Granting Institution in Arizona
R4-39-104. ~~Conditional Licensure~~ Requirements for Conditional Licensure to Operate ~~Operating~~ a New, Private, Non-Accredited ~~New~~ Vocational Institution in Arizona
R4-39-105. ~~Licensure~~ Requirements for Regular Licensure to Continue to Operate ~~Continued Operation of~~ an Existing, Private, Non-Accredited, Vocational Institution in Arizona
R4-39-106. ~~Conditional Licensure~~ Requirements for Conditional Licensure to Operate ~~Operating~~ a New, Private, Non-Accredited, Degree-Granting Institution in Arizona
R4-39-107. Requirements ~~Requirement~~ for Provisional Licensure to Operate ~~of a~~ an Existing, Private, Non-Accredited, Degree-Granting Institution in Arizona

ARTICLE 1. DEFINITIONS, LICENSURE, REPORTING

R4-39-103. Requirements for Regular Licensure to Operate ~~Operating~~ a Private, Accredited, Vocational or ~~and~~ Degree-Granting Institution in Arizona

A. A private, vocational or degree-granting institution that is institutionally accredited or has ~~Institutions which have~~ each of its programs ~~vocational program or degree program they offer~~ accredited ~~or have institutional accreditation~~ with an accrediting agency recognized by the United States Department of Education or the Council ~~on~~ for Higher Education ~~Postsecondary~~ Accreditation shall apply ~~make application~~ to the Board for a regular license before operating ~~to operate~~ in Arizona.

~~**B.** In order to be licensed, in addition to the completed verified application, the accredited institution or program shall annually submit to the Board a letter from each recognized accrediting agency by whom the institution or program is accredited confirming the current accredited status of the institution or each program offered. This letter shall be certified as true and correct by an authorized administrative official of the institution submitting it.~~

B. To be regularly licensed to operate, a private, accredited, vocational institution shall demonstrate compliance with A.R.S. § 32-3021(B) and a private, accredited, degree-granting institution shall demonstrate compliance with A.R.S. § 32-3022(B), and both shall submit the following to the Board for verification, review, and administrative action:

1. A completed, verified license application;
2. A letter from each recognized accrediting agency by whom the institution or its programs are accredited that confirms the current accredited status of the institution or its programs and is certified as true and correct by an authorized administrative official of the institution;
3. A copy of the institution's current catalog, required by the institution's accrediting agency, certified as true and correct by an authorized administrative official of the institution;

4. A copy of the institution's student enrollment agreement or equivalent documentation, required by the institution's accrediting agency; and
5. Documents specified in R4-39-104(B)(5) through R4-39-104(B)(15).

C. To continue to be regularly licensed, a private, accredited, vocational institution shall demonstrate compliance with A.R.S. § 32-3021(B) and a private, accredited, degree-granting institution shall demonstrate compliance with A.R.S. § 32-3022(B), and both shall annually submit to the Board for verification, review and administrative action documents specified in subsections (B)(1) through (B)(3) and in R4-39-104(B)(5), (B)(6), (B)(9), (B)(11), and (B)(15).

D.~~C.~~ In addition to the grounds for disciplinary action described in A.R.S. § 32-3051, the Board shall ~~may~~ discipline an accredited, vocational or degree-granting institution that is regularly licensed if the institution ~~which~~:

~~1.~~ Fails to comply with applicable accreditation standards or applicable federal standards as determined by the Board;
2.~~1.~~ Loses its institutional or program accreditation;
3.~~2.~~ Fails to notify the Board in writing within 20 ~~twenty~~ days of any change in any certificate of accreditation; or
4.~~3.~~ Intentionally or negligently misrepresents any material information in documents ~~materials~~ or testimony presented ~~submitted~~ to the Board;.
~~4. Fails to comply with applicable accreditation standards.~~

R4-39-104. ~~Conditional Licensure~~ Requirements for Conditional Licensure to Operate ~~Operating~~ a New, Private, Non-Accredited, ~~New~~ Vocational Institution in Arizona

~~A. In order to be conditionally licensed to operate a vocational institution or program, in addition to the completed, verified application, each new institution shall comply with the requirements specified in R4-39-105.A.1. through 10.~~

A. A new, private, vocational institution that is not institutionally accredited and does not have each of its programs accredited with an accrediting agency recognized by the United States Department of Education or the Council for Higher Education Accreditation shall apply to the Board for a conditional license before operating vocational programs in Arizona.

B. To be conditionally licensed to operate vocational programs a new, private, non-accredited, vocational institution shall demonstrate compliance with A.R.S. § 32-3021(B) and shall submit the following to the Board for verification, review and administrative action:

1. A completed, verified license application;
2. A surety bond in the amount of $15,000 on a form approved by the Board. A cash deposit in the amount of $15,000 may be submitted instead of a surety bond. A receipt for the cash deposit from the state treasurer shall suffice as evidence of the deposit;
3. A copy of the institution's current catalog, required by R4-39-301, certified as true and correct by an authorized administrative official of the institution;
4. A copy of the institution's student enrollment agreement specified in R4-39-310(A)(1);
5. Proof of insurance, sufficient to protect the assets of the institution in the event of damage or a finding of liability;
6. Current annual financial statements, compiled or reviewed in accordance with standards established by the American Institute of Certified Public Accountants or audited in accordance with generally accepted auditing standards and prepared in accordance with generally accepted accounting principles. The financial statements shall include a balance sheet, statement of operations, statement of changes in financial position and appropriate footnotes with an accountant's report, prepared and signed by an independent certified or public accountant currently licensed by the Arizona State Board of Accountancy or, if applicable, the accountancy Board located in the state of the institution's corporate or home office. Additional financial information may be required by the Board;
7. Course of study information on each program offered by the institution, including information on graduate employment opportunities and practitioner requirements;
8. A copy of each certificate or diploma awarded by the institution;
9. A copy of the institution's published student grievance procedure that provides details regarding the institutional complaint process and references the student's right to file a complaint with the Board;
10. A sample copy of every document and media presentation that is or is intended to be advertised or presented to potential students;
11. A resume for each faculty member, director and owner;
12. Line drawings or photographs that describe in detail the facilities, and a list of equipment and materials of the institution;
13. A copy of the most recent fire department inspection report;
14. An agent license application for each person soliciting students, if applicable; and
15. Other information deemed necessary by the Board.

C.~~B.~~ Before issuing ~~Prior to the issuance of~~ a conditional license to operate vocational programs to a new, private, non-accredited, vocational institution, Board staff or a Board-appointed ~~and at least once during this year of operation,~~ ~~an~~ on-site verification ~~inspection~~ team ~~appointed by the chairman of the Board~~ shall visit the institution and confer with the administrative officers, faculty, students, if applicable, and other individuals, and make ~~such~~ examinations that ~~as~~ are necessary to obtain an accurate reflection of the institution's financial responsibility, management capabilities, programs, facilities, and equipment. After the visit, Board staff or the on-site verification team shall prepare and submit to the Board a written report of its findings. The Board shall ~~receive and~~ review and use the written report ~~of the on-site inspection team concerning the visit, as one of the bases~~ in determining whether to grant a conditional license to the institution ~~eligibility for licensure. Members of the on-site inspection team may include staff, members of the Board and other qualified persons.~~

D.~~C.~~ During its ~~the~~ 1 ~~one~~-year ~~period~~ of conditional licensure, ~~the~~ a new, private, non-accredited, vocational institution shall not use terms such terms as "licensed", "approved" or "accredited" in conjunction with the institution or the Board. If the institution wishes to refer to its licensure during this time period, it shall use the term "conditional license."

E.~~D.~~ In addition to the grounds for disciplinary action described in A.R.S. § 32-3051, the Board shall take disciplinary action against a new, private, non-accredited, vocational institution that intentionally or negligently misrepresents any material information in documents or testimony presented to the Board. ~~Misrepresentation in any materials or testimony submitted to the Board may result in disciplinary action.~~

R4-39-105. ~~Licensure~~ Requirements for Regular Licensure to Continue to Operate ~~Continued Operation of~~ an Existing, Private, Non-Accredited, Vocational Institution in Arizona

~~A. In order to continue to be licensed in Arizona, in addition to the completed, verified application, each non-accredited vocational institution shall annually submit the following:~~

~~1. A copy of the current catalog or bulletin, as required by R4-39-301, certified as true and correct by an authorized administrative official of the institution.~~

~~2. Current annual financial statements, compiled or reviewed in accordance with standards established by the American Institute of Certified Public Accountants or audited in accordance with generally accepted auditing standards and prepared in accordance with generally accepted accounting principles, including a balance sheet, statement of operations, statement of changes in financial position and appropriate footnotes with an accountant's report, prepared and signed by an independent certified or public accountant currently licensed by the Arizona State Board of Accountancy or, if applicable, the accountancy Board located in the state of the institution's corporate or home office. Additional financial information may be required by the Board.~~

~~3. A surety bond in the amount of $15,000 on a form approved by the Board. A cash deposit in the amount of $15,000 may be accepted in lieu of the surety bond. A receipt for the cash deposit with the State Treasurer shall suffice as evidence of the deposit.~~

~~4. A resume for each faculty member, director, and owner.~~

~~5. A copy of the student enrollment contract as specified in R4-39-309 and R4-39-310.A.~~

~~6. A copy of the most recent fire department inspection report.~~

~~7. A copy of each certificate of diploma awarded by the institution.~~

~~8. Line drawings or photographs which describe in detail the facilities, and a list of equipment and materials of the institution.~~

~~9. An agent license application for each person soliciting students other than in the office or place of business of the institution.~~

~~10. A sample copy of every document and media presentation which is or is intended to be advertised or presented to potential students.~~

A. Upon expiration of a conditional license obtained in compliance with R4-39-104, an existing, private, vocational institution that is not institutionally accredited and does not have each of its programs accredited with an accrediting agency recognized by the United States Department of Education or the Council for Higher Education Accreditation shall apply to the Board for a regular license to continue to operate non-accredited vocational programs in Arizona.

B. To be regularly licensed, an existing, private, non-accredited, vocational institution shall demonstrate compliance with A.R.S. § 32-3021(B) and shall submit the following to the Board for verification, review, and administrative action:

1. A completed, verified license application;
2. A valid surety bond or cash deposit, if required by A.R.S. § 32-3023(I); and
3. Documents specified in R4-39-104(B)(3), (B)(5), (B)(6), (B)(9), (B)(11), and (B)(15).

C.~~B.~~ Before issuing a regular license to an existing, private, non-accredited, vocational institution, the Board shall conduct an on-site verification as described in R4-39-104(C) ~~An on-site inspection of facilities, equipment, and program may be conducted prior to Board consideration of applications as specified in R4-39-104(B). Members of the on-site inspection team may include staff, members of the Board and other qualified persons.~~

D. To continue to be regularly licensed, an existing, private, non-accredited, vocational institution shall demonstrate continued compliance with A.R.S. § 32-3021(B) and shall annually submit to the Board for verification, review, and administrative action documents specified in subsections (B)(1) through (B)(3).

E.~~C.~~ In addition to the grounds for disciplinary action described in A.R.S. § 32-3051, the Board shall take disciplinary action against an existing, private, non-accredited, vocational institution that intentionally or negligently misrepresents any material information in documents or testimony presented to the Board. ~~Misrepresentation in any materials or testimony submitted to the Board may result in disciplinary action.~~

R4-39-106. ~~Conditional Licensure~~ Requirements for Conditional Licensure to Operate ~~Operating~~ a New, Private, Non-Accredited, Degree-Granting Institution in Arizona

~~A. In order to be conditionally licensed to grant degrees, in addition to the completed, verified application, each institution shall:~~

~~1. Have operated in Arizona as a non-degree-granting educational institution for a minimum of nine (9) months.~~

~~2. Comply with the requirements specified in R4-39-105(A)(1) through (10).~~

~~3. Declare its intention to attempt to achieve accreditation status by submitting the name of each accrediting agency recognized by the United States Department of Education or Council on Postsecondary Education to which the institution has applied for accreditation or has submitted a written commitment to apply for accreditation. This information shall be signed by an authorized administrative official of the institution.~~

A. A new, private, degree-granting institution that is not institutionally accredited and does not have each of its programs accredited with an accrediting agency recognized by the United States Department of Education or the Council for Higher Education Accreditation shall apply to the Board for a conditional license before operating degree programs or granting degrees in Arizona.

B. To be conditionally licensed to operate degree programs or grant degrees, a new, private, non-accredited, degree-granting institution shall demonstrate its intent and ability to make reasonable and timely progress toward obtaining accreditation from an accrediting agency recognized by the United States Department of Education or the Council for Higher Education Accreditation. "Reasonable and timely" means the continuous, diligent and successful pursuit of the various stages of accreditation within the time periods established, by the accrediting agency and as determined by the Board.

C. To be conditionally licensed to operate degree programs or grant degrees, a new, private, non-accredited, degree-granting institution shall demonstrate compliance with A.R.S. § 32-3021(B) and shall submit the following to the Board for verification, review, and administrative action:

1. A completed, verified license application;
2. Evidence that the institution is in compliance with subsection (B). Evidence of compliance includes:
   a. A copy of the written commitment to apply for accreditation that the institution has submitted to each recognized accrediting agency to which the institution plans to apply for accreditation, certified

as true and correct by an authorized administrative official of the institution; and

b. An explanation to the accreditation process and the timeline required to make reasonable and timely progress toward obtaining accreditation, for each recognized accrediting agency to which the institution plans to apply for accreditation; and

3. Documents specified in R4-39-104(B)(2) through (B)(15).

D.~~B.~~ Before issuing ~~Prior to issuance of~~ a conditional license to operate degree programs or grant degrees to a new, private, non-accredited, degree-granting institution, the Board shall conduct an on-site verification as described in R4-39-104(C). ~~grant degrees, an on-site inspection team appointed by the chairman of the Board shall visit the institution and confer with the administrative officers, faculty, students, if applicable, and other individuals, and make such examinations as are necessary to obtain an accurate reflection of the institution's programs, facilities and equipment. The Board shall receive and review the report of the on-site inspection team concerning the visit, as one of the bases in determining eligibility for licensure. Members of the on-site inspection team may include staff, members of the Board and other qualified persons.~~

E.~~C.~~ During its ~~the~~ 1 ~~one~~-year ~~period~~ of conditional licensure to operate degree programs or grant degrees, ~~the~~ a new, private, non-accredited, degree-granting institution shall not use terms such ~~terms~~ as "licensed", "approved", or "accredited" in conjunction with the institution or the Board. If the institution wishes to refer to its licensure during this time ~~period~~, it shall use the term "conditional license".

F.~~D.~~ In addition to the grounds for disciplinary action described in A.R.S. § 32-3051, the Board shall take disciplinary action against a new, private, non-accredited, degree-granting institution that intentionally or negligently misrepresents any material information in documents or testimony presented to the Board. ~~Misrepresentation in any material or testimony submitted to the Board may result in disciplinary action.~~

R4-39-107. Requirements ~~Requirement~~ for Provisional Licensure to Operate ~~of a~~ an Existing, Private, Non-Accredited, Degree-Granting Institution in Arizona

A. Upon expiration of a conditional license obtained in compliance with R4-39-106, an existing, private, degree-granting institution that is not institutionally accredited and does not have each of its programs accredited with an accrediting agency recognized by the United States Department of Education or the Council for Higher Education Accreditation shall apply to the Board for a provisional license to continue to operate degree programs or grant degrees in Arizona.

B.~~A.~~ To ~~In order to~~ be provisionally licensed to operate degree programs or grant degrees, an existing, private, non-accredited, degree-granting ~~the~~ institution shall ~~must~~ demonstrate reasonable and timely progress toward obtaining accreditation with an accrediting agency recognized by the United States Department of Education or the Council ~~on~~ for Higher Education ~~Postsecondary~~ Accreditation. "Reasonable and timely" means the continuous, diligent, and successful pursuit of the various stages of accreditation within the time periods established by the accrediting agency and as determined by the Board. ~~This information shall be signed by an authorized administrative official of the institution.~~

~~B. In addition to the completed, verified application, the institution shall:~~

~~1. Comply with the requirement specified in R4-39-105(A)(1) through (10).~~

~~2. Submit to the Board a letter from each recognized accrediting agency specified in subsection A, confirming the current status of the institution.~~

C. To be provisionally licensed, an existing, private, non-accredited, degree-granting institution shall demonstrate compliance with A.R.S. § 32-3021(B) and shall submit the following to the Board for verification, review, and administrative action:

1. A completed, verified license application;
2. Evidence that the institution is in compliance with subsection (B). Evidence of compliance includes:
   a. Proof that the institution has applied for accreditation with 1 or more recognized accrediting agencies;
   b. A report on the current status of the institution's progress toward accreditation, certified as true and correct by an authorized administrative official of the institution; and
   c. A letter from each recognized accrediting agency to which the institution has applied confirming the current status of the institution's progress toward accreditation;
3. A valid surety bond or cash deposit, if required by A.R.S. § 32-3023(I); and
4. Documents specified in R4-39-104(B)(3) through (B)(6), (B)(9) through (B)(11), and (B)(15).

D. To continue to be provisionally licensed, an existing, private, non-accredited, degree-granting institution shall demonstrate continued compliance with A.R.S. § 32-3021(B) and shall annually submit to the Board for verification, review and administrative action documents specified in subsection (C)(1), (C)(2)(b), (C)(2)(c), (C)(3), and (C)(4). The Board shall deny provisional licensure to an existing private, non-accredited, degree-granting institution that is not proceeding through the accreditation process in a reasonable and timely manner as determined by the Board.

E.~~C.~~ Before issuing ~~Prior to the issuance of~~ a provisional license to an existing, private, non-accredited, degree-granting institution, the Board shall conduct an on-site verification as described in R4-39-104(C). ~~grant degrees, an on-site inspection team appointed by the chairman of the Board shall visit the institution and confer with the administrative officers, faculty, students, and other individuals, and make such examinations as are necessary to obtain an accurate reflection of the institution's programs, facilities and equipment. The on-site inspection team shall confirm that actual instruction relating to each degree is being provided. The Board shall receive and review the report of the on-site inspection team concerning the visit, as one of the bases in determining eligibility for licensure. Members of the on-site inspection team may include staff, members of the Board and other qualified persons.~~

F.~~D.~~ During the period of provisional licensure, ~~the~~ an existing, private, non-accredited, degree-granting institution shall not use terms such ~~terms~~ as "licensed", "approved", or "accredited" in conjunction with the institution or the Board. If the institution wishes to refer to its licensure, it shall use the term "provisional license". ~~The Board may grant one year extensions of provisional approval so long as the institution remains in compliance with these rules and is proceeding through the accreditation process in a reasonable and timely manner. "Reasonable and timely" shall mean diligent pursuit of accreditation, including taking all steps required by the accrediting body within the time limitations imposed by the accrediting body.~~

G.~~E.~~ In addition to the grounds for disciplinary action described in A.R.S. § 32-3051, the Board shall take disciplinary action against an existing private, non-accredited, degree-granting institution that intentionally or negligently misrepresents any material information in documents or testimony presented to the Board. ~~Misrepresentation in any materials or testimony submitted to the Board may result in disciplinary action.~~

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

PREAMBLE

1. Sections Affected / Rulemaking Action

R9-22-201	Repeal
R9-22-201	New Section
R9-22-202	Repeal
R9-22-203	Repeal
R9-22-204	Repeal
R9-22-204	New Section
R9-22-205	Repeal
R9-22-205	New Section
R9-22-206	Amend
R9-22-207	Repeal
R9-22-207	New Section
R9-22-208	Repeal
R9-22-208	New Section
R9-22-209	Repeal
R9-22-209	New Section
R9-22-210	Amend
R9-22-211	Amend
R9-22-212	Repeal
R9-22-212	New Section
R9-22-213	Amend
R9-22-214	Repeal
R9-22-215	Repeal
R9-22-215	New Section
R9-22-216	Repeal
R9-22-216	New Section
R9-22-217	Repeal
R9-22-217	New Section
R9-22-218	Repeal

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

   Authorizing statute: A.R.S. § 36-2903.01(H)

   Implementing statute: A.R.S. §§ 36-2903(N), 36-2903.01(G) and (N), 36-2905.05(D), 36-2907, 36-2908, and 36-2909.

3. The effective date of the rules:

   September 22, 1997

4. A list of all previous notices appearing in the Register addressing the final rule:

   Notice of Rulemaking Docket Opening: 2 A.A.R. 4297, October 18, 1996.

   Notice of Rulemaking Docket Opening: 3 A.A.R. 1610, June 6, 1997.

   Notice of Proposed Rulemaking: 3 A.A.R. 1460, June 6, 1997.

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

   Name: Cheri Tomlinson

   Address: AHCCCS
   801 East Jefferson, MD 4200
   Phoenix, Arizona 85034

   Telephone: (602) 417-4198

Fax: (602) 256-6756

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**
The Administration made revisions to improve the clarity, conciseness, and understandability of the rules. In addition, the Administration consolidated and organized all standards, limitations, and exclusions pertaining to each service. This organization of rules provides a more logical sequence for the audience.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
Not applicable.

8. **The summary of the economic, small business, and consumer impact:**
The impact of the changes will be nominal. Individuals and entities that will benefit from the enhanced clarity and conciseness of the language include:

- AHCCCS;
- ALTCS program contractors; and
- ALTCS providers.

Over the long term, the transfer of processing and payment for medically necessary services provided to ventilator dependent members from AHCCCS to program contractors benefit all parties by streamlining the processing and payment of ALTCS member claims. The cost of this change is nominal because program contractors already have claims processing and payment systems in place, and because the costs associated with these services will be included in program contractor capitation payments.

Individuals and entities that were considered but will not be directly affected include:

- Taxpayers and the general public;
- ALTCS members;
- The business community, except for the 2 program contractors that are private business entities;
- Political subdivisions;
- Local governments, except for the counties that serve as program contractors; and
- Other governmental agencies, except for DES/DDD, the program contractor for the developmentally disabled population.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**
The changes between the proposed rules and final rules are minimal. Grammatical, verb tense, and punctuation changes were made throughout the Article to make the rule more clear, concise, and understandable.

The differences between the proposed rule and final rule include the revisions noted below:

- R9-22-201(A)(1) - Permits contractors to waive referral form requirement;
- R9-22-201(A)(1)(b) - Permits consultation for behavioral health treatment services with either the PCP, the contractor, or its designee;
- R9-22-201(C) - Clarified that payment for services may be denied if prior authorization is not obtained from the Administration or contractor;
- R9-22-201(D)(8) - Clarified contractors are responsible for all medically necessary services when out of a contractor's service area for an extended period of time;
- R9-22-201(G)(1) - Clarifies that the contractor list the requested services and the itemized cost for services not covered by AHCCCS;
- R9-22-201(H)(1) - Cited the Health Care Group rules for restrictions and limitations of Article 2;
- R9-22-201(H)(2)(b) - Clarified that noncovered services must be paid from Administration revenue or contract funds unrelated to Title XIX services;
- R9-22-204(A)(1) - Deleted reference to level of care/tiered rates;
- R9-22-204(A)(1)(g)(i) - Changed 72 hours to 3 days;
- R9-22-205(A)(8) and (9) - Added covered immunizations and covered preventive health services as covered PCP services;
- R9-22-205(B)(1) - Added language allowing the Administration to waive a referral for specialty care and other services;
- R9-22-205(B)(5)(c) - Clarified the abortion language;

• R9-22-205(B)(6)(b) - Deleted language requiring the Administration's prior authorization for nonemergency medical conditions of the eye for individuals 21 years of age or older;

• R9-22-208(1) - Permits the Administration to waive the referral for laboratory, radiology, and imaging services;

• R9-22-209(C) - Permits the Administration to waive the referral form for pharmaceutical services;

• R9-22-209(C) - Permits PCPs, contractors, or its designee to authorize pharmaceutical services;

• R9-22-209(D)(2)(c) - Moved (D)(2)(c) to (D)(6);

• R9-22-211(A)(2) - Deleted incorrect A.R.S. reference;

• R9-22-211(B)(1) - Cross-referenced contract for medically necessary nonemergency transportation;

• R9-22-211(D)(1) - Requires approval and prior authorization to go to health care service site that is out of the contractor's service area;

• R9-22-211(D)(2) - Changed the word "attendant" to the word "escort";

• R9-22-211(E)(1) - Reformatted language regarding limitations for reimbursing family members, friends or neighbors;

• R9-22-211(E)(1) - Adds language permitting reimbursement for transportation services, if the services are authorized by the contractor or it's designee;

• R9-22-212(A)(1) - Permits the Administration to waive the referral form for DME, medical supplies, and orthotic and prosthetic devices;

• R9-22-212(G)(2) - Requires prior authorization for DME rental costs and DME purchases of $200 or more;

• R9-22-213(B)(2)(b) - Changed language from "behavioral health diagnosis" to "behavioral health evaluation";

• R9-22-215(A)(13) - Permits the Administration to waive the referral form for acute episodes of mental illness or substance abuse; and

• R9-22-215(B) - Removed prior authorization requirement for chemotherapy.

10. A summary of the principal comments and the agency response to them:

The Administration received written comments from 2 organizations regarding this Article. These comments can be categorized into 7 areas:

• Provide definitions;

• Clarify prior authorization requirements;

• Update A.R.S. references;

• Address Perry vs. Kelly issues;

• Specify reimbursement for ambulance services;

• Clarify that when a member requests a service not covered by AHCCCS, they must receive a document itemizing the cost to the member or eligible person; and

• Revise the language to be more clear, concise, and understandable.

The Administration made numerous changes based upon the public comments which are identified in question #9. However, not all requested changes were made. Some of these requested changes will be addressed in upcoming rule packages. For example, in 9 A.A.C. 22, Article 1, Definitions will address those concerns regarding terms that relate to Covered Services. As for Perry vs. Kelly, a separate rule package is in process. For more specific information regarding the public comments, the Concise Explanatory Statement (CES) is available upon request from the Administration.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable.

12. Incorporations by reference and their location in the rules:

42 U.S.C. 1396d(r)(5), April 1, 1990, incorporated at R9-22-213.

13. Was this rule previously adopted as an emergency rule?

Not applicable.

14. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

ARTICLE 2. SCOPE OF SERVICES

Section

ARTICLE 2. SCOPE OF SERVICES

R9-22-201. ~~Scope of Covered Services~~

~~A. Covered services provided to enrolled members. Covered services shall be medically necessary and provided by, or under the direction of, a primary care physician, specialist or dentist under the referral of a primary care physician. Nurse practitioners and physician assistants may provide covered services in appropriate affiliation with a primary care physician. Delegation for the provision of primary care services to a practitioner shall not diminish the role or responsibility of the delegating primary care physician, as defined in these rules. Certain services, ordinarily provided under Title XIX of the Social Security Act, as amended, are specifically excluded from coverage under AHCCCS pursuant to waiver agreements between the Administration and the Health Care Financing Administration of the U.S. Department of Health and Human Services. Some services require prior authorization by the Administration.~~

~~B. Covered services provided to eligible but not enrolled persons. Only emergency medical services provided by licensed providers in compliance with provisions of this Chapter shall be covered for non-categorical persons who have been determined eligible by the county but who are not enrolled.~~

~~C. Covered state and federal emergency services are set forth in R9-22-217.~~

~~D. Restrictions, exclusions and prior authorizations. The restrictions, exclusions and prior authorizations set forth under this Article shall not apply to the following groups:~~

~~1. Public and private employers selecting AHCCCS as a health care option for their employees and wishing to negotiate for extended benefits.~~

~~2. Prepaid capitated contractors electing to provide non-covered services. The costs associated with the provisions of those services to the categorically eligible, indigent and medically needy shall not be included in development or negotiation of capitation rates. Non-covered services must be paid for out of administrative revenue or other plan funds.~~

R9-22-201. General Requirements

A. In addition to requirements and limitations specified in this Chapter, the following general requirements apply:

1. Covered services provided to a member shall be medically necessary and provided by, or under the direction of, a primary care provider or a dentist; specialist services shall be provided under referral from, and in consultation with, the primary care provider.
   a. The role or responsibility of a primary care provider, as defined in these rules, shall not be diminished, by the primary care provider delegating the provision of primary care for a member to a practitioner.
   b. Behavioral health screening and evaluation services may be provided, without referral from a primary care provide. Behavioral health treatment services shall be provided only under referral from and in consultation with the PCP, or upon authorization by the contractor or its designee.
   c. The contractor may waive the referral requirements.
2. Covered services provided to an eligible person through the AHCCCS Administration shall be medically necessary and provided by, or under the direction of, an attending physician, practitioner, or dentist;
3. Services shall be rendered in accordance with state and federal laws and regulations, the Arizona Administrative Code and AHCCCS contractual requirements;
4. Only emergency medical services provided in compliance with this Chapter shall be covered for a noncategorically eligible person for 48 hours prior to enrollment in the system;
5. Experimental services as determined by the director, or services provided primarily for the purpose of research, shall not be covered;
6. AHCCCS services shall be limited to those services that are not covered for a member or eligible person who is a Medicare beneficiary;
7. Services or items, if furnished gratuitously, are not covered and payment shall be denied;
8. Personal care items are not covered and payment shall be denied;
9. Medical or behavioral health services shall not be covered if provided to:
   a. An inmate of a prison;
   b. A person who is in residence at an institution for the treatment of tuberculosis; or

c. A person who is in an institution for the treatment of mental disorders, unless provided according to Article 12.

B. Services shall be provided by AHCCCS registered personnel or facilities that meet state and federal requirements, and are appropriately licensed or certified to provide the services.

C. Payment for services or items requiring prior authorization may be denied if prior authorization by the Administration or contractor is not obtained. Services provided during the prior period coverage do not require authorization. Emergency services under A.R.S. § 36-2908 do not require prior authorization.
1. For an eligible person, the AHCCCS Administration shall prior authorize services based on the diagnosis, complexity of procedures, and prognosis, and be commensurate with the diagnostic and treatment procedures requested by the eligible person's attending physician or practitioner.
2. Services for unrelated conditions, requiring additional diagnostic and treatment procedures, require additional prior authorization.
3. In addition to the requirements of Article 7, written documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.

D. Covered services rendered to a member shall be provided within the service area of the member's primary contractor except when:
1. A primary care provider refers a member out of the contractor's area for medical specialty care;
2. A covered service that is medically necessary for a member is not available within the contractor's service area;
3. A net savings in service delivery costs can be documented without requiring undue travel time or hardship for a member or the member's family;
4. A member is placed in a nursing facility located out of the contractor's service area;
5. Services provided are during the prior period coverage time-frame authorized under Article 3; and
6. The service is otherwise authorized by the contractor based on medical practice patterns and cost or scope of service considerations.

E. When a member is traveling or temporarily residing out of the service area of the member's contractor, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

F. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in these rules and in contract.

G. If a member or eligible person requests the provision of a service that is not covered by AHCCCS or not authorized by the contractor, the service may be rendered to the member or eligible person by an AHCCCS-registered service provider under the following conditions:
1. A document that lists the requested services and the itemized cost of each is prepared by the contractor and provided to the member or eligible person; and
2. The signature of the member or eligible person is obtained in advance of service provision indicating that the services have been explained to the member or eligible person, and that the member or eligible person accepts responsibility for payment.

H. The Director shall determine the circumstances under which an eligible person may receive services, other than emergency services, from service providers outside the eligible person's county of residence, or outside the state. Criteria considered by the Director in making this determination shall include availability and accessibility of appropriate care, and cost effectiveness.

I. If a member is referred out of the contractor's service area to receive an authorized medically necessary service for an extended period of time, the contractor shall also provide all other medically necessary covered services for the member during that time.

J. The restrictions, limitations, and exclusions in this Article shall not apply to the following groups:
1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. Ch. 27, and wishing to negotiate for extended benefits; and
2. Contractors electing to provide noncovered services.
a. The costs associated with providing any noncovered service to a member shall not be included in development or negotiation of capitation.
b. Noncovered services shall be paid from administrative revenue or other contractor funds, unrelated to Title XIX services.

K. In accordance with A.R.S. § 36-2907 the Director may, upon 30 days advance written notice to contractors and counties, modify the list of services for all members except those members categorically eligible according to Title XIX of the Social Security Act, as amended.

R9-22-202. ~~Covered Services~~ Repealed

~~Subject to the exclusions and limitations contained in this Chapter, the following services shall be covered:~~
~~1. Outpatient health services.~~
~~2. Laboratory, X-ray and medical imaging services.~~
~~3. Pharmacy services.~~
~~4. Medical supplies, medical equipment and prosthetic devices.~~
~~5. Inpatient hospital services.~~
~~6. Emergency services.~~
~~7. Emergency ambulance and medically necessary transportation.~~
~~8. Emergency dental care and extractions.~~
~~9. Medically necessary dentures.~~
~~10. Early and periodic screening, diagnosis and treatment services (EPSDT), subject to the limitations set forth in this Article.~~
~~11. Podiatry services beginning October 1, 1985.~~
~~12. AHCCCS covered services described in paragraphs (1) through (4) and (6) through (11) of this Section provided in the home, in a nursing facility.~~
~~13. Home health services pursuant to A.R.S. § 36-2907(D).~~
~~14. Nursing facility services, including room and board, provided in lieu of hospitalization for up to 90 days in any contract year. Prior authorization from the Administration is required to provide these services to nonenrolled eligible persons.~~
~~15. Home health services, including nursing services, may be covered under deferred liability as determined by the Director in accordance with R9-22-336 for up to 14 days. Home health care services, including nursing services, provided within 90 days after discharge from the hospital and in lieu of continued hospitalization shall be covered under reinsurance in accordance with R9-22-503.~~
~~16. Family planning services, including drugs, supplies, devices, and surgical procedures provided to delay or~~

prevent pregnancy. Family planning services are limited to:

a. Contraceptive counseling, medication, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service.
b. Sterilizations.
c. Natural family planning education or referral.

R9-22-203. Excluded Services Repealed

A. The following services are excluded:
1. Services or items furnished solely for cosmetic purposes.
2. Services or items requiring prior authorization for which prior authorization has not been obtained.
3. Services not rendered in accordance with AHCCCS rules or contractual requirements.
4. Services or items furnished gratuitously or for which charges are not usually made.
5. Services provided in an institution for the treatment of tuberculosis or an institution for the treatment of mental disorders, except services provided to a categorically eligible person pursuant to Article 12.
6. Hearing aids, eye examinations for prescriptive lenses, and prescriptive lenses for eligible persons 21 years of age or older. Glasses or contact lenses are not excluded if they are the sole prosthetic device after a cataract extraction.
7. Treatment of the basic conditions of alcoholism and drug addiction.
8. Services determined by the Director to be experimental or provided primarily for the purpose of research.
9. Nursing facility services, except as provided in R9-22-202(12) and (14) and A.A.C. Title 9, Chapter 28.
10. Services of private or special duty nurses other than when medically necessary and prior authorized.
11. Sex change operations, infertility services, and reversal of surgically induced infertility (sterilization).
12. Care not deemed necessary by the Director, the responsible contractor, or the responsible primary care physician and not specifically provided for in these rules.
13. Medical services provided to a person who is an inmate of a public institution or who is in the custody of a state mental health facility.
14. Outpatient speech and occupational therapy for eligible persons 21 years of age and older.
15. Physical therapy prescribed only as a maintenance regimen.
16. Orthognathic surgery for eligible persons 21 years of age and older.
17. Artificial or mechanical hearts and xenografts.
18. Heart transplantation, except as specified in A.R.S. § 36-2907(E).
19. Abortions and hysterectomies that are not medically necessary.
20. Abortion counseling.
21. Organ or tissue transplantations which are experimental or are not medically necessary or are not required by state or federal law.
22. Personal comfort items.

B. Except as otherwise provided in R9-22-202(15) and A.A.C. Title 9, Chapter 28, the following services are excluded when provided in a nursing facility:
1. Nursing services:
a. Administration of medication.
b. Tube feedings.
c. Personal care services (assistance with bathing and grooming).
d. Routine testing of vital signs.
e. Assistance with eating.
f. Maintenance of catheters.
2. Basic patient care equipment and sickroom supplies, including, but not limited to:
a. First aid supplies such as band-aids, tape, ointments, peroxide, alcohol and over the counter remedies.
b. Bathing and grooming supplies.
c. Identification devices.
d. Skin lotions.
e. Medication cups.
f. Alcohol wipes, cotton balls and cotton rolls.
g. Rubber gloves -- nonsterile.
h. Laxatives.
i. Beds and accessories.
j. Thermometers.
k. Ice bags.
l. Rubber sheeting.
m. Passive restraints.
n. Glycerin swabs.
o. Facial tissue.
p. Enemas.
q. Heating pads.
r. Diapers.
s. Alcoholic beverages.
3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating.
4. Any services that are included in a facility's room and board charge or services that are required of the facility to meet state or county licensure.
5. Administrative physician visits made solely for the purpose of meeting state licensure or county certification requirements.
6. Physical therapy prescribed only as a maintenance regimen.
7. Bed pans, urinals, walkers and wheelchairs, bedside commodes and geriatric chairs except when provided in a licensed supervisory care facility or a certified adult foster care facility for the purpose of maintaining the member at such level. Such medical equipment shall be ordered by a physician.

R9-22-204. Out-of-area Coverage

A. Covered services shall be provided within the service area of the contractor except as follows:
1. When a primary care provider refers a member out of the contractor's service area for medical specialty care.
2. Coverage for members traveling or temporarily residing out of their contractor's service area is restricted to emergency care services, unless otherwise authorized by the Administration.
3. When a covered service is not available within the contractor's service area.
4. When net savings in transportation costs can reasonably be expected.
5. In cases where the current attending providers are out of the contractor's service area and a deferred liability situation exists as specified in Article 3 of these rules.
6. When members are placed in a nursing facility located out of the contractor's service area.

~~7. When a retroactive coverage situation exists as specified in Article 3 of these rules.~~

~~8. As otherwise authorized in writing by the Administration based on medical practice patterns, cost or scope of service considerations.~~

~~B. The Director will determine the circumstances under which an eligible person may be enrolled with, or receive reimbursable routine covered services from, contracting or noncontracting providers outside the member's county of residence, or outside the state. Criteria to be considered by the Director in making this determination shall include:~~

~~1. Availability and accessibility of appropriate care.~~

~~2. Cost benefits.~~

R9-22-204. Inpatient General Hospital Services

A. Inpatient services provided in a general hospital shall be covered by contractors or provided by fee-for-service providers or noncontracting providers and shall include:

1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
   a. Maternity care;
   b. Neonatal intensive care (NICU);
   c. Intensive care (ICU);
   d. Surgery;
   e. Nursery;
   f. Routine care; and
   g. Behavioral health (psychiatric) care.
      i. Emergency crisis behavioral health services may be provided for 3 days per acute episode and a maximum of 12 days per AHCCCS contract year for each member or eligible person unless services are provided under Article 12.
      ii. For purposes of this Section, the AHCCCS contract year shall be October 1 through September 30.
2. Ancillary services as specified by the Director and included in contract:
   a. Labor, delivery and recovery rooms, and birthing centers;
   b. Surgery and recovery rooms;
   c. Laboratory services;
   d. Radiological and medical imaging services;
   e. Anesthesiology services;
   f. Rehabilitation services;
   g. Pharmaceutical services and prescribed drugs;
   h. Respiratory therapy;
   i. Blood and blood derivatives;
   j. Central supply items, appliances, and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services;
   k. Maternity services; and
   l. Nursery and related services.

B. The following limitations apply to general inpatient hospital services that are provided by fee-for-service providers and for which the Administration is financially responsible:

1. The cost of inpatient hospital accommodation for an eligible person shall be incorporated into the rate paid for the level of care as specified in subsection (A)(1).
2. Prior authorization shall be obtained from the Administration for the following inpatient hospital services provided to an eligible person:
   a. Nonemergency and elective admission, including psychiatric hospitalization, shall be authorized prior to the scheduled admission;
   b. Elective surgery, with the exception of voluntary sterilization procedures, shall be authorized prior to the surgery;
   c. An emergency hospitalization that exceeds 3 days or an intensive care unit admission that exceeds 1 day;
   d. Hospitalization beyond the number of days initially authorized shall be covered only if determined medically necessary through AHCCCS Administration concurrent team review;
   e. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury shall be authorized prior to service delivery; and
   f. Behavioral health services for an eligible person who is 18, 19, or 20 years of age that are provided on an emergency basis for crisis stabilization, and exceed 3 days per episode, or 12 days per contract year.

R9-22-205. ~~Outpatient Health Services~~

~~A. The outpatient health services to be provided by contractors and the services reimbursable to capped fee-for-service providers or noncontracting providers are as follows:~~

~~1. Ambulatory surgery and anesthesiology services not specifically excluded.~~

~~2. Physician's services, including patient education.~~

~~3. Pharmaceutical services and prescribed drugs to the extent authorized by these rules and applicable provider contracts.~~

~~4. Treatment of medical conditions of the eye.~~

~~5. Laboratory services.~~

~~6. X-ray and medical imaging services.~~

~~7. Services of allied health professionals when supervised by a physician.~~

~~8. Nursing services provided in an outpatient health care facility.~~

~~9. Medical supplies and equipment ordinarily furnished to persons receiving outpatient health services to the extent that they are covered services and authorized by a primary care physician.~~

~~10. The use of emergency, examining or treatment rooms when required for the provision of physician's services. Access to an emergency room and medical emergency services shall be provided on a twenty-four-hour-a-day, seven-day-a-week basis in the contractor's service area.~~

~~11. Consultation for acute mental health episodes provided by a psychiatrist or psychologist which is prescribed by a primary care physician for stabilization, evaluation and treatment plan determination, except consultation services provided to a categorically eligible person pursuant to Article 12.~~

~~12. Home health visits as medically necessary~~

~~13. Home physician visits as medically necessary.~~

~~14. Dialysis as limited by these rules.~~

~~15. Specialty care physician services shall be considered covered services only when referred by a primary care physician.~~

~~16. Rehabilitation services, excluding occupational therapy and speech therapy for persons 21 years of age or older.~~

~~17. Beginning October 1, 1985, total parenteral nutrition services.~~

~~18. Beginning October 1, 1985, outpatient podiatry services performed by a podiatrist licensed pursuant to Title 32, Chapter 7, which are ordered by a primary care physician.~~

~~19. Orthognathic surgery for eligible persons under 21 years of age.~~

~~20. Physical examinations, periodic health examinations, health assessments, physical evaluations, diagnostic work-ups, or health protection packages, that include groups of tasks or procedures designed to:~~

~~a. Determine risk of disease,~~

~~b. Provide early detection of disease,~~

~~c. Detect the presence of injury or disease at any stage,~~

~~d. Establish a treatment plan for injury or disease,~~

~~e. Evaluate the results or progress of a treatment plan or the disease, or~~

~~f. Establish the presence and characteristics of a physical disability which may be the result of disease or injury.~~

~~21. Beginning October 1, 1987, nurse midwife services.~~

~~B. The following limitations apply to capped fee-for-service providers and nonproviders:~~

~~1. Dialysis is limited to services not covered by Title XVIII, Social Security Act, as amended.~~

~~2. Services provided upon referral from a primary care physician are limited to those services or conditions for which the referral was made or for which authorization was given.~~

~~C. Prior authorization. Prior authorization from the Administration is required for capped fee-for-service providers or nonproviders to provide the following services:~~

~~1. Dialysis not covered by Title XVIII.~~

~~2. Elective ambulatory surgery and anesthesia services, with the exception of voluntary sterilization procedures.~~

~~3. Services or items provided to improve personal appearance after a condition, illness or injury.~~

~~4. Acute mental health care services.~~

~~5. Home health services.~~

~~6. Rehabilitative services.~~

~~7. Orthognathic surgery for eligible persons under 21 years of age.~~

~~8. Beginning October 1, 1985, outpatient podiatry services performed by a podiatrist licensed pursuant to Title 32, Chapter 7, which are ordered by a primary care physician.~~

~~D. Written documentation of treatment is required for reimbursement of the services in subsection (C) in addition to the requirements of Article 7 of these rules.~~

~~E. Whenever a physical examination is performed with the primary intent to accomplish one or more of the objectives listed in subsection (A), paragraph (19) of this Section, it will be a service or benefit covered by AHCCCS and/or its contractors, except when there is an additional or alternative objective that is designed to satisfy the demands of outside public or private agencies, including preparation of required documentation for that agency's use. Examples of such alternative objectives include physical examinations and resulting documentation for:~~

~~1. Qualification for insurance,~~

~~2. Pre-employment physical evaluation,~~

~~3. Qualification for sports or physical exercise activities,~~

~~4. Pilots examination (FAA).~~

~~5. Disability certification for the purpose of establishing any kind of periodic payments,~~

~~6. Evaluation for establishing third party liabilities, or~~

~~7. Physical ability to perform functions that have no relation to primary objectives listed in subsection (A), paragraph (19) of this Section.~~

R9-22-205. Physician and Primary Care Physician and Practitioner Services

A. Primary care provider services shall be furnished by a physician or practitioner and shall be covered for members when rendered within the provider's scope of practice under A.R.S. Title 32. An eligible person may receive these services through an attending physician or practitioner. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:

1. Periodic health examinations and assessments,
2. Evaluations and diagnostic workups,
3. Medically necessary treatment,
4. Prescriptions for medications and medically necessary supplies and equipment,
5. Referrals to specialists or other health care professionals when medically necessary,
6. Patient education,
7. Home visits when determined medically necessary,
8. Covered immunizations, and
9. Covered preventive health services.

B. The following limitations and exclusions apply to physician and practitioner services and primary care provider services:

1. Specialty care and other services provided to a member upon referral from a primary care provider or to an eligible person upon referral from the attending physician or practitioner shall be limited to the services or conditions for which the referral is made, or for which authorization is given, unless referral is waived by the Administration;
2. If a physical examination is performed with the primary intent to accomplish 1 or more of the objectives listed in subsection (A), it shall be covered by the member's contractor, or the Administration, except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
   a. Qualification for insurance,
   b. Pre-employment physical evaluation,
   c. Qualification for sports or physical exercise activities,
   d. Pilot's examination (FAA),
   e. Disability certification for establishing any kind of periodic payments,
   f. Evaluation for establishing 3rd-party liabilities, or
   g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A).
4. Orthognathic surgery shall be covered only for members and eligible persons who are less than 21 years of age.
5. The following services shall be excluded from AHCCCS coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
   b. Abortion counseling services;
   c. Abortions, unless authorized under federal or state law;
   d. Services or items furnished solely for cosmetic purposes; and
   e. Hysterectomies, unless determined to be medically necessary.
6. Prior authorization from the Administration shall be required for fee-for-service providers to render the following services to eligible persons:

a. Elective or scheduled surgeries with the exception of voluntary sterilization procedures.
b. Services or items provided to reconstruct or improve personal appearance after an illness or injury.

R9-22-206. Organ and Tissue Transplantation Services

~~A. The following organ and tissue transplantation services are covered for members and eligible persons except those individuals receiving services through the federal or state emergency services programs.~~
~~1. Kidney transplantation;~~
~~2. Heart transplantation;~~
~~3. Liver transplantation;~~
~~4. Autologous and allogeneic bone marrow transplantation;~~
~~5. Cornea transplantation;~~
~~6. Lung transplantation;~~
~~7. Heart-lung transplantation;~~
~~8. Other organ transplantation may be covered if the transplantation is required by federal law for categorically eligible persons or members under the age of 21 years and if other statutory criteria are met;~~
~~9. Immunosuppressant medications, chemotherapy, and other related services.~~

~~B. The following limitations shall apply to organ and tissue transplantation services.~~
~~1. Organ or tissue transplantation services determined by the Director to be experimental services, or services provided primarily for the purpose of research, are not covered.~~
~~2. Artificial or mechanical hearts and xenografts are not covered services.~~
~~3. Organ and tissue transplantation services under subsections (A)(2), (3), (4), (6), and (7) are covered for members and eligible persons who are medically indigent, medically needy, eligible assistance children, and eligible low-income children, only if funding is available as specified in A.R.S. § 36-2907.~~
~~4. Organ and tissue transplantation services are not covered during the fee-for-service emergency services only period for eligible persons who are medically indigent, medically needy, eligible assistance children, and eligible low-income children, except for those persons eligible for services pursuant to Laws 1995, Third Special Session, Chapter 1, § 5.~~

A. The following organ and tissue transplantation services shall be covered for a member or eligible person as specified in A.R.S. § 36-2907 if prior authorized and coordinated with the member's contractor, or the Administration for eligible persons:
1. Kidney transplantation;
2. Cornea transplantation;
3. Heart transplantation;
4. Liver transplantation;
5. Autologous and allogeneic bone marrow transplantation;
6. Lung transplantation;
7. Heart-lung transplantation;
8. Other organ transplantation if the transplantation is required by federal law for a categorically eligible person or member less than the age of 21 years and if other statutory criteria are met; and
9. Immunosuppressant medications, chemotherapy, and other related services.

B. The following limitations shall apply to organ and tissue transplantation services:
1. Artificial or mechanical hearts and xenografts are not covered services.
2. Organ or tissue transplantation services specified in subsection (A) are covered for a member or eligible person who is medically indigent or medically needy or for eligible assistance children and eligible low-income children only if funding is available as specified in A.R.S. § 36-2907;
3. Organ and tissue transplantation services are not covered during the fee-for-service emergency services only period for a member or eligible person who is medically indigent or medically needy or for eligible assistance children and eligible low-income children, except for persons eligible for services under Laws 1995, Ch. 1, Section 5 (3rd Special Session); and
4. Organ and tissue transplantation services are not covered under the state and federal emergency services programs.

R9-22-207. ~~Pharmaceutical services~~

~~A. Pharmaceutical services shall be available to members during customary business hours and shall be located within reasonable travel distance.~~
~~B. The following limitations shall apply:~~
~~1. Drugs personally dispensed by a physician or dentist are not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.~~
~~2. Prescriptions in excess of a 30-day supply or a 100-unit dose are excluded from covered services, with the exception of prescriptions for chronic illnesses which shall be limited to a 100-day supply or 100-unit doses, whichever is more.~~
~~3. The following are excluded from covered services:~~
~~a. Nonprescription drugs and medicines except when appropriate alternative over-the-counter drugs are available and are less costly than prescription drugs.~~
~~b. Drugs and medicines not prescribed by the member's primary care physicians, physicians and dentists under their referral, or authorized practitioners.~~
~~c. Refilling of a prescription in excess of the number specified, or any refill dispensed after one year from the original order.~~
~~4. All changes in, or additions to, the original prescription shall be approved by the authorized prescriber and shall clearly indicate the date of change and be initialed by the dispensing pharmacist.~~

R9-22-207. Dental Services

A. Emergency dental care, which encompasses the following services, shall be covered:
1. Emergency oral diagnostic examination including laboratory and radiographs when necessary to determine an emergent condition;
2. Immediate palliative treatment, including extractions when professionally indicated, for relief of severe pain associated with an oral or maxillofacial condition;
3. Initial treatment for acute infection;
4. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone, or soft tissue;
5. Preoperative procedures; and

6. Anesthesia appropriate for optimal patient management.

B. The following limitations shall apply to emergency dental services provided by the Administration's fee-for-service providers:
   1. Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection. Root canals are limited to treatment for acute infection or to eliminate pain;
   2. Routine restorative procedures and routine root canal therapy are not emergency services;
   3. Radiographs are limited to symptomatic teeth for use as a diagnostic tool preceding treatment and to support the need for, and provision of, dentures;
   4. Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxillae and mandible; and
   5. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.

C. Covered denture services include medically necessary dental services and procedures associated with, and including, the provision of dentures.

D. The following limitations shall apply to dentures provided by the Administration's fee-for-service providers:
   1. Provision of dentures for cosmetic purposes is not a covered service;
   2. Extractions of asymptomatic teeth are not covered unless their removal constitutes the most cost effective dental procedure for the provision of dentures;
   3. Radiographs are limited to use as a diagnostic tool preceding treatment of symptomatic teeth and to support the need for, and provision of, dentures; and
   4. Prior authorization of dental services for an eligible person is required from the Administration for the following:
      a. Provision of medically necessary dentures;
      b. Replacement, repair, or adjustment to dentures; and
      c. Provision of obturators or other prosthetic appliances for restoration or rehabilitation.

R9-22-208. ~~Medical Supplies, Durable Equipment, Orthotic and Prosthetic Devices~~

~~A. Medical supplies, durable equipment, orthotic and prosthetic devices prescribed by a primary care physician, a practitioner or by a physician upon referral from the primary care physician, qualify as covered services when they are medically necessary and not excluded by these rules.~~
   ~~1. Medical supplies include but are not limited to surgical dressings, splints, casts and other consumable items covered under Title XVIII and which are not reusable and are provided to the member or eligible person.~~
   ~~2. Medical equipment includes but is not limited to wheelchairs, walkers, hospital beds, bed pans and other durable items purchased or rented for the member or eligible person.~~
   ~~3. Prosthetic and orthotic devices include only those items that are essential for the rehabilitation of the member or eligible person.~~

~~B. The following limitations shall apply:~~
   ~~1. Medical equipment may be purchased or rented only when there are no reasonable alternative resources from which the medically necessary medical equipment can be obtained at no cost.~~
   ~~2. The contractor shall furnish all medically necessary medical equipment on a rental or purchase basis, whichever is less expensive. Total expense or rental shall not exceed purchase price.~~
   ~~3. Reasonable repairs or adjustment of purchased medical equipment is covered when necessary to make the equipment serviceable and when the cost of repair is less than the cost of rental or purchase of another unit.~~
   ~~4. For capped fee-for-service providers, changes in, or additions to, the original order for medical equipment shall be approved by the primary care physician or authorized prescriber and shall be indicated clearly and initialed by the vendor. No change or addition to the original order for medical equipment may be made after the claim for services has been submitted to the Administration without prior written notification of such change or addition.~~
   ~~5. Rental fees shall terminate no later than the end of the month in which the member no longer needs the medical equipment as certified by the authorized provider, or when the member is no longer eligible or enrolled with a contractor, except during transitions of care as specified by the Director.~~

~~C. Exclusions:~~
   ~~1. Personal incidentals including items for personal cleanliness, body hygiene and grooming are not covered unless needed to treat a medical condition under a prescription.~~
   ~~2. First aid supplies are not covered unless they are provided in accordance with a prescription.~~
   ~~3. Hearing aids and prescriptive lenses are not covered for eligible persons who are 21 years of age and older. Glasses and contact lenses are not excluded if they are the sole prosthetic device after a cataract extraction.~~

~~D. Prior authorization:~~
   ~~1. Capped fee-for-service providers shall obtain authorization from the Administration prior to providing consumable medical supplies ordered for a member or eligible person when the cost for such supplies exceeds $50.00 per month.~~
   ~~2. Capped fee-for-service providers shall obtain authorization from the Administration prior to providing durable medical equipment and prosthetic or orthotic devices when the cost for the item exceeds $200.00.~~

~~E. Liability and ownership:~~
   ~~1. Purchased durable medical equipment provided to members that is no longer needed may be disposed of in accordance with each contractor's policy.~~
   ~~2. The state shall retain title to purchased durable medical equipment supplied to eligible non-enrolled persons who are no longer enrolled and who no longer require its usage.~~

R9-22-208. Laboratory, Radiology, and Medical Imaging Services

Laboratory, radiology, and medical imaging services shall be covered services if:
   1. Prescribed for members by a primary care provider or a dentist, or if prescribed by a physician or practitioner upon referral from the primary care provider or dentist, unless referral is waived by the Administration;
   2. Provided for an eligible person by a fee-for-service provider and the services are prescribed by the attending physician, practitioner, or dentist of the eligible person;

3. Provided in hospitals, clinics, physician offices, or other health care facilities by licensed health care providers; and
4. Provided by a provider that meets all applicable state and federal license and certification requirements and provides only services that are within the scope of practice stated in the provider's license or certification.

R9-22-209. ~~Inpatient Hospital Services~~

~~A. Inpatient hospital services means medically necessary services provided by or under the direction of a primary care physician, practitioner or by a specialty physician or dentist on referral from a primary care physician. The inpatient hospital services covered by contractors and the hospital services provided by capped fee-for-service providers or noncontracting providers shall include:~~

~~1. Routine services, including:~~
~~a. Hospital accommodations.~~
~~b. Intensive care and coronary care unit.~~
~~c. Nursing services necessary and appropriate for the member's medical condition.~~
~~d. Dietary services.~~
~~e. Medical supplies, appliances and equipment ordinarily furnished to hospital inpatients billed as part of routine services and included in the daily room and board charge.~~
~~f. Acute mental health care services up to limits of 72 hours per acute episode and 12 days per contract year for each eligible person other than categorically eligible persons pursuant to Article 12. For purposes of this Section, the contract year shall be considered as October 1 through September 30.~~

~~2. Ancillary services, including:~~
~~a. Labor, delivery and recovery rooms, and birthing centers.~~
~~b. Surgery and recovery rooms.~~
~~c. Laboratory services.~~
~~d. Radiological and medical imaging services.~~
~~e. Anesthesiology services.~~
~~f. Rehabilitation services.~~
~~g. Pharmaceutical services and prescribed drugs.~~
~~h. Respiratory therapy.~~
~~i. Blood and blood derivatives.~~
~~j. Central supply items, appliances and equipment not ordinarily furnished to all patients and which are customarily reimbursed as ancillary services.~~
~~k. Maternity services.~~
~~l. Nursery and related services.~~
~~m. Chemotherapy.~~
~~n. Dialysis as limited by these rules~~
~~o. Beginning October 1, 1985, total parenteral nutrition services.~~
~~p. Orthognathic surgery for eligible persons under 21 years of age.~~
~~q. Beginning October 1, 1985, podiatry services performed by a podiatrist licensed pursuant to Title 32, Chapter 7, which are ordered by a primary care physician.~~

~~B. Limitations. The following limitations apply to inpatient hospital services provided by capped fee-for-service providers or nonproviders:~~
~~1. Inpatient hospital accommodations are limited to no more than a semi-private rate except when patients must be isolated for medical reasons.~~
~~2. Dialysis is limited to services not covered by Title XVIII, Social Security Act, as amended.~~

~~C. Prior authorization for non-enrolled eligible persons. Prior authorization for covered services is required to provide the following services. Written documentation of treatment is required for reimbursement of the services in this subsection in addition to the requirements of Article 7.~~
~~1. Dialysis not covered by Title XVIII.~~
~~2. Services or items furnished to cosmetically reconstruct appearance after the onset of trauma or serious injury.~~
~~3. Elective surgery with the exception of voluntary sterilization procedures.~~
~~4. Any emergency hospitalization beyond three days or intensive care unit (ICU) admission beyond 24 hours requires prior authorization. Based on the diagnosis, complexity of procedures and prognosis, the Administration may authorize an additional maximum number of inpatient hospital days for the diagnostic and treatment procedures requested by a primary care physician. Unrelated conditions requiring additional diagnostic and treatment procedures require additional prior authorization. Continued hospitalization beyond the number of days initially authorized shall be covered only if re-authorization was previously obtained which will be based on the same criteria as initial authorization requests.~~
~~5. Nonemergency and elective admissions require prior authorization before the eligible person is admitted. Based on the diagnosis, complexity of procedures and prognosis, the Administration shall authorize a maximum number of inpatient hospital days for the diagnostic and treatment procedures requested by a primary care physician. Unrelated conditions requiring additional diagnostic and treatment procedures require additional prior authorization. Continued hospitalization beyond the number of days initially authorized shall be covered only if re-authorization was previously obtained which will be based on the same criteria as initial authorization requests.~~
~~6. Emergency services pursuant to A.R.S. § 36-2908(E) do not require prior authorization.~~
~~7. Acute mental health care services which extend beyond 24 hours of inpatient hospitalization.~~
~~8. Beginning October 1, 1985, podiatry services performed by a podiatrist licensed pursuant to Title 32, Chapter 7, which are ordered by a primary care physician.~~
~~9. Kidney transplantation not covered by Medicare and all heart transplantation.~~

R9-22-209. **Pharmaceutical Services**

A. Pharmaceutical services may be provided by an inpatient or outpatient provider including hospitals, clinics, or appropriately licensed health care facilities and pharmacies.
B. The Administration or its contractor shall make pharmaceutical services available during customary business hours and shall be located within reasonable travel distance of a member's residence.
C. Pharmaceutical services shall be covered if prescribed for a member by the member's primary care provider or dentist, or if prescribed by a specialist upon referral from the primary care provider unless referral is waived by the Administration or upon authorization by the contractor or its designee. Pharmaceutical services provided for an eligible person shall be covered if prescribed by the attending physician, practitioner, or dentist.
D. The following limitations shall apply to pharmaceutical services:

1. A medication personally dispensed by a physician or dentist is not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. A prescription in excess of a 30 day supply or a 100-unit dose is not covered unless:
   a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is more.
   b. The member or eligible person will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is more.
3. A nonprescription medication is not covered unless an appropriate, alternative over-the-counter medication is available and less costly than a prescription medication.
4. A prescription is not covered if filled or refilled in excess of the number specified, or if an initial prescription or refill as dispensed after 1 year from the original prescribed order.
5. Approval by the authorized prescriber is required for all changes in, or additions to, an original prescription. The date of a prescription change is to be clearly indicated and initialed by the dispensing pharmacist.

E. A contractor shall monitor and take necessary actions to ensure that a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being, is provided sufficient services to eliminate any gap in the required pharmaceutical regimen.

R9-22-210. Emergency Medical and Behavioral Health Services

~~A. Emergency services may be provided to eligible persons by contracting providers, noncontracting providers and nonproviders. If the person claims to be covered by AHCCCS, the provider of emergency services shall verify through the Administration eligibility and enrollment status to determine the need for notification to and prior authorization from the Administration or contractor, and liability for services.~~

~~B. Notification procedures. Members enrolled in prepaid capitated contracting health plans. Noncontracting providers and nonproviders furnishing emergency services to members who are enrolled with a prepaid capitated contract provider must notify the member's contractor within 12 hours of the time the member registers for services. If the member's medical condition is not emergent, as specified in the definitions of emergency medical services in Article 1 of these rules, the nonprovider or noncontracting provider must notify the member's contractor prior to the initiation of treatment. Failure to provide timely notice may constitute cause for denial of payment.~~

A. Emergency medical services and behavioral health emergency or crisis stabilization services may be provided to a member or eligible person by licensed providers, registered with AHCCCS to provide the services.

B. The provider of emergency services shall verify eligibility and enrollment status through the Administration to determine the need for notification to a contractor for a member, or the Administration for an eligible person, and to determine the party responsible for payment of services rendered.

C. Access to an emergency room and emergency medical and behavioral health services shall be available 24 hours per day, 7 days per week in each contractor's service area. The use of examining or treatment rooms shall be available when required by a physician or practitioner for the provision of emergency services.

D. Consultation provided by a psychiatrist or psychologist shall be covered as an emergency service if required to evaluate or stabilize an acute episode of mental illness or substance abuse.

E. Emergency services do not require prior authorization but providers shall comply with the following notification requirements:
1. Providers, nonproviders, and noncontracting providers furnishing emergency services to a member shall notify the member's contractor within 12 hours of the time the member presents for services;
2. Providers of emergency services to an eligible person are not required to notify the Administration; and
3. If a member's medical condition is determined not to be an emergency medical condition, as defined in Article 1 of this Chapter, the provider shall notify the member's contractor before initiation of treatment and follow the prior authorization requirements and protocol of the contractor regarding treatment of the member's nonemergent condition. Failure to provide timely notice or comply with prior authorization requirements of the contractor constitutes cause for denial of payment.

R9-22-211. Transportation Services

~~A. Emergency ambulance services.~~
~~1. Emergency ambulance transportation for eligible persons is a covered service. Payment is limited to the cost of transporting eligible persons in a ground or air ambulance to the nearest appropriate provider or medical facility capable of meeting the eligible person's medical needs, when no other means of transportation is both appropriate and available.~~
~~2. If the eligible person is enrolled with a contractor, the ground or air ambulance provider providing emergency transportation shall notify the member's contractor within ten working days from the date of transport. Failure to notify shall be cause for denial or nonpayment of claims.~~
~~3. Determination of whether an emergency transport is medically necessary is based upon an assessment of the eligible person's medical condition at the time of transport.~~

~~B. Medically necessary transportation.~~
~~1. Medically necessary transportation services shall be arranged for or provided by contractors according to prior authorization guidelines for members who are unable to arrange or pay for their own transportation to a service site or location when free transportation services are not available.~~
~~2. When an eligible person who is not enrolled requires medically necessary transportation, due to an inability to arrange or pay for such services, or such services are not available at no cost, the attending physician or practitioner shall order those services in writing. Such transportation services require prior authorization of the Administration.~~

~~C. Air ambulance services are covered only if:~~
~~1. The air ambulance transport is initiated upon the request of an emergency response unit, a law enforcement official, a hospital, a physician, or clinic medical staff; and~~
~~2. The point of pickup is inaccessible by ground ambulance; or great distances or other obstacles are involved in getting emergency services to the eligible person and transporting the eligible person to the nearest hospital or~~

~~other provider with appropriate facilities; or the medical condition of the eligible person requires timely ambulance service and ground ambulance service will not suffice.~~

~~D. Meals, lodging and attendant services.~~

~~1. Expenses for meals, lodging and transportation for an eligible person while en route to or returning from a health care service site, as prior authorized, out of the eligible person's service area or county of residence are AHCCCS covered services.~~

~~2. Meals, lodging and transportation expenses of an attendant, who may be a family household member accompanying an eligible person out of the eligible person's service area, shall be covered if the services of the attendant are ordered in writing by the primary care physician. A salary for an attendant is covered if the attendant is not a part of the eligible person's family household.~~

~~E. Limitations~~

~~1. Family household members, friends and neighbors may be reimbursed for providing transportation services only if the services are ordered in writing by the primary care physician and free transportation or public transportation is not available.~~

~~2. A charitable organization routinely providing transportation services at no cost to ambulatory or chairbound persons shall not charge or seek reimbursement from the Administration or contractors for the provision of such services to eligible persons but may enter into subcontractual agreements with AHCCCS contractors for medically necessary transportation services provided under such arrangements.~~

~~3. Payment for meals, lodging and transportation of an attendant and a salary not to exceed federal minimum wage for such attendant is allowed only when the eligible person requires covered services that are not available in the service area. If the eligible person is admitted to an inpatient facility, meals, lodging and a salary for the attendant are covered only when accompanying the member en route to and returning from the facility.~~

~~F. Prior authorization. Prior authorization for transportation services provided or ordered by a capped fee-for-service provider is required for the following:~~

~~1. All medically necessary transportation services.~~

~~2. All meals, lodging and services of an attendant.~~

A. Emergency ambulance services.

1. Emergency ambulance transportation shall be a covered service for a member or eligible person. Payment shall be limited to the cost of transporting the member or eligible person in a ground or air ambulance:
   a. To the nearest appropriate provider or medical facility capable of meeting the member's or eligible person's medical needs; and
   b. When no other means of transportation is both appropriate and available.
2. A ground or air ambulance transport that originates in response to a 911 call or other emergency response system shall be reimbursed by the member's contractor, or the Administration for eligible persons, if the medical condition at the time of transport justified a medically necessary ambulance transport. No prior authorization is required for reimbursement of these transports.
3. Determination of whether transport is medically necessary shall be based upon the medical condition of the member or eligible person at the time of transport.
4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure to notify the contractor may constitute cause for denial of claims.
5. Notification to the Administration of emergency transportation provided to an eligible person is not required, but the provider shall submit documentation with the claim which justifies the service.

B. Medically necessary nonemergency transportation.

1. As specified in contract, contractors shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange or pay for the member's own transportation to a service site or location if free transportation services are not available.
2. If an eligible person requires medically necessary nonemergency transportation due to an inability to arrange or pay for the services, or the services are not available at no cost, the attending physician or practitioner shall order those services.

C. Air ambulance services shall be covered only if:

1. The air ambulance transport is initiated upon the request of an emergency response unit, a law enforcement official, a hospital or clinic medical staff member, a physician, or a practitioner;
2. The point of pickup is inaccessible by ground ambulance, or great distances, or other obstacles are involved in getting emergency services to the member or eligible person or transporting the member or eligible person to the nearest hospital or other provider with appropriate facilities; and
3. The medical condition of the member or eligible person requires timely ambulance service and ground ambulance service will not suffice.

D. Meals, lodging, and escort services.

1. Expenses for meals, lodging, and transportation for a member or eligible person while en route to, or returning from, an approved and prior authorized health care service site out of the member's or eligible person's service area or county of residence shall be an AHCCCS covered service.
2. Meals, lodging, and transportation expenses of an escort, who may be a family household member accompanying an eligible person or member out of the eligible person's or member's service area, shall be covered if the services of the escort are ordered in writing by the member's primary care provider or the eligible person's attending physician or practitioner. A salary for an escort shall be covered if the escort is not a part of the eligible person's or member's family household.

E. Limitations.

1. Family, household members, friends, and neighbors shall be reimbursed for providing transportation services only if:
   a. The services are ordered in writing by the member's PCP or the eligible person's attending physician or practitioner, or
   b. The services are authorized by the member's contractor or designee, and
   c. Appropriate free transportation or public transportation is not available.
2. A charitable organization routinely providing transportation services at no cost to ambulatory or chairbound

persons shall not charge or seek reimbursement from the Administration or contractors for the provision of these services to a member or eligible person but may enter into subcontractual agreements with AHCCCS contractors for medically necessary transportation services provided to their members.

3. Payment for meals, lodging, and transportation of an escort and a salary not to exceed the federal minimum wage shall be is allowed only when the member or eligible person requires covered services that are not available in the service area. If the member or eligible person is admitted to an inpatient facility, meals, lodging, and a salary for the escort shall be covered only when accompanying the member or eligible person en route to, and returning from, the inpatient facility.

F. Subject to A.R.S. § 36-2908(E), prior authorization from the Administration for transportation services provided for eligible persons is required for the following:

1. Medically necessary nonemergency transportation services not originated through a 911 call; and
2. All meals, lodging, and services of an escort accompanying the eligible person under subsection (D)(2).

R9-22-212. ~~Emergency dental services~~

~~A. Emergency dental care includes the following services:~~

~~1. Relief of severe pain associated with an oral or maxillofacial condition, limited to immediate palliative treatment, but including extractions when professionally indicated.~~

~~2. Initial treatment for acute infection.~~

~~3. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone or soft tissue.~~

~~4. Laboratory and preoperative procedures including examination and radiographs.~~

~~5. Anesthesia appropriate for optimal patient management.~~

~~B. The following limitations apply to emergency dental services provided by capped fee-for-service providers:~~

~~1. Extractions are limited to emergency care but should not be the treatment of choice.~~

~~2. The treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from performed stainless steel, pulp caps and pulpatomies only for the tooth causing pain or in the presence of active infection. Root canals are limited to six anterior teeth (uppers and lowers) only and only when indicated as treatment for acute infection or to eliminate pain.~~

~~3. Routine restorative procedures and routine root canal therapy are not considered emergency services.~~

~~4. Radiographs are limited to use as a diagnostic tool preceding treatment of symptomatic teeth and to support the need and provision of dentures.~~

~~5. Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxillae and mandible.~~

~~6. Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.~~

R9-22-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices

A. Medical supplies, durable equipment, and orthotic and prosthetic devices shall be covered services if:

1. Prescribed for a member by the member's primary care provider or if prescribed by a physician or practitioner upon referral from the primary care provider unless referral is waived by the Administration, or
2. Prescribed by the attending physician or practitioner of an eligible person, and
3. Provided in compliance with requirements of this Chapter.

B. Medical supplies include consumable items covered under Medicare that are provided to a member or eligible person and that are not reusable.

C. Medical equipment includes any durable item, appliance, or piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member or eligible person.

D. Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a member or eligible person.

E. Prescriptive lenses are covered if they are the sole prosthetic device after a cataract extraction;

F. The following limitations apply:

1. If medical equipment can not be reasonably obtained from alternative resources at no cost, the medical equipment shall be furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased.
2. Reasonable repair or adjustment of purchased medical equipment shall be covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. Changes in, or additions to, an original order for medical equipment shall be approved by the member's primary care provider or authorized prescriber, or prior authorized by the Administration for eligible persons, and shall be indicated clearly and initialed by the vendor. No change or addition to the original order for medical equipment may be made after a claim for services has been submitted to the member's contractor, or the Administration for eligible persons, without prior written notification of the change or addition.
4. Rental fees shall terminate:
   a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member or eligible person no longer needs the medical equipment;
   b. When the member or eligible person is no longer eligible for AHCCCS services; or
   c. When the member is no longer enrolled with a contractor, with the exception of transitions of care as specified by the Director.
5. Personal incidentals including items for personal cleanliness, body hygiene, and grooming shall not be covered unless needed to treat a medical condition and provided in accordance with a prescription.
6. First aid supplies shall not be covered unless they are provided in accordance with a prescription.
7. Hearing aids and prescriptive lenses shall not be covered for members or eligible persons who are 21 years of age and older, unless authorized under subsection (E).

G. Fee-for-service providers shall obtain prior authorization from the Administration before providing:

1. Consumable medical supplies exceeding $50.00 per month, or

2. Durable medical equipment or prosthetic or orthotic devices for an eligible person for all rentals or if the cost to purchase the equipment or device exceeds $200.00.

H. Liability and ownership.
1. Purchased durable medical equipment provided to members but which is no longer needed may be disposed of in accordance with each contractor's policy.
2. The state shall retain title to purchased durable medical equipment supplied to eligible persons who become ineligible or no longer require its use.
3. If customized durable medical equipment is purchased by the Administration for an eligible person, or for a member by the contractor, the equipment will remain with the person during times of transition, or upon loss of eligibility.
a. For purposes of this Section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a member's or eligible person's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.
b. Customized equipment obtained fraudulently by a member or an eligible person shall be returned for disposal to the member's contractor, or to the Administration if the customized equipment was purchased for an eligible person.

R9-22-213. Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)

~~A. The services set forth below are covered for eligible persons from birth to 21 years of age:~~
~~1. Screening services, including:~~
~~a. Comprehensive health and developmental history.~~
~~b. Comprehensive unclothed physical examination.~~
~~c. Appropriate immunizations according to age and health history.~~
~~d. Laboratory tests.~~
~~e. Health education, including anticipatory guidance.~~
~~2. Vision services, including diagnosis and treatment for defects in vision, and eye examinations for the provision of prescriptive lenses and provision of lenses.~~
~~3. Hearing services, including diagnosis and treatment for defects in hearing, and testing and the provision of hearing aids.~~
~~4. Dental screening and diagnosis and treatment of dental disease, and the provision of dentures and other prosthetic devices.~~
~~5. Mental health services for categorically eligible persons, pursuant to Article 12.~~
~~6. Other necessary health care, diagnostic services, treatment and measures, such as speech services, required by Section 1905(r)(5) of the Social Security Act, April 1, 1990, incorporated by reference herein and on file with the Office of the Secretary of State.~~

~~B. All providers of EPSDT services shall meet the following conditions: Services shall be conducted under the direction of the primary care physician.~~
~~1. Performing tests and examinations in accordance with the AHCCCS Administration Periodicity Schedule.~~
~~2. Referring eligible persons as necessary for dental diagnosis and treatment, and necessary specialty care.~~

~~C. Contractors shall meet the following additional conditions:~~
~~1. Services shall include:~~
~~a. Providing information to members concerning EPSDT services.~~
~~b. Notifying members regarding the initiation of EPSDT screening and subsequent appointments according to the Periodicity Schedule.~~
~~2. Contractors shall offer and provide, if requested, necessary assistance with transportation to and from providers, pursuant to R9-22-211, and with scheduling appointments for services.~~
~~3. Contractors may refer members with special health care needs to the Children's Rehabilitative Services program.~~

A. The following EPSDT services shall be covered for a member or eligible person less than 21 years of age:
1. Screening services, including:
a. Comprehensive health and developmental history;
b. Comprehensive unclothed physical examination;
c. Appropriate immunizations according to age and health history;
d. Laboratory tests; and
e. Health education, including anticipatory guidance;
2. Vision services, including:
a. Diagnosis and treatment for defects in vision;
b. Eye examinations for the provision of prescriptive lenses; and
c. Provision of prescriptive lenses;
3. Hearing services, including:
a. Diagnosis and treatment for defects in hearing;
b. Testing to determine hearing impairment; and
c. Provision of hearing aids;
4. Dental services including:
a. Emergency dental services as specified in R9-22-207;
b. Preventive services including screening, diagnosis, and treatment of dental disease; and
c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery;
6. Behavioral health services under Article 12;
7. Other necessary health care, diagnostic services, treatment and measures required by 42 U.S.C. § 1396d(r)(5), April 1, 1990, incorporated by reference and on file with the Administration and the Office of Secretary of State. This incorporation by reference contains no future editions or amendments.

B. All providers of EPSDT services shall meet the following standards:
1. Provide services by or under the direction of, the member's primary care provider or dentist, or the eligible person's attending physician, practitioner, or dentist.
2. Perform tests and examinations in accordance with the AHCCCS Administration Periodicity Schedule.
a. Refer members and eligible persons as necessary for dental diagnosis and treatment, and necessary specialty care.
b. Refer members and eligible persons as necessary for behavioral health evaluation and treatment services.

C. Contractors shall meet the following additional conditions for EPSDT members:
1. Provide information to members and their parents or guardians concerning EPSDT services;
2. Notify members and their parents or guardians regarding the initiation of EPSDT screening and subsequent appointments according to the AHCCCS Administration Periodicity Schedule; and
3. Offer and provide, if requested, necessary assistance with transportation to and from providers, in accordance

with R9-22-211, and with scheduling appointments for services.

D. Members and eligible persons with special health care needs may be referred to the Children's Rehabilitative Service program.

R9-22-214. ~~Medically necessary dentures~~ Repealed

~~A. Covered denture services include those medically necessary dental services and procedures associated with, and including, the provision of dentures.~~

~~B. The following limitations apply to dentures provided by capped fee-for-service providers:~~

~~1. Provision of dentures for cosmetic purposes is not a covered service.~~

~~2. Extractions of asymtomatic teeth are not covered unless their removal constitutes the most cost effective dental procedure for the provision of dentures.~~

~~3. Radiographs are limited to use as a diagnostic tool preceding treatment of symptomatic teeth and to support the need and provision of dentures.~~

~~4. Members shall receive only one set of dentures during any given five year period, unless the Administration determines that replacement within that period is medically indicated.~~

~~5. Unless authorized by the Administration, no more than five repairs and/or adjustments will be allowed during any given five year period.~~

~~C. Prior written authorization.~~

~~1. Provision of dentures by capped fee for service providers shall require prior written authorization from the Administration. Requests for replacements, repairs or adjustments require prior written authorization from the Administration.~~

~~2. Provision of obturators and other prosthetic appliances for restoration or rehabilitation provided by capped fee-for-service providers shall require prior authorization by the Administration.~~

R9-22-215. ~~Notification of changes in covered services~~

~~In accordance with A.R.S. § 36-2907(F) the Director may, upon 30 days advance written notice to contractors and counties, modify the list of services for all members except those members categorically eligible pursuant to Title XIX of the Social Security Act, as amended.~~

R9-22-215. Other Medical Professional Services

A. The following medical professional services provided to a member by a contractor, or an eligible person through the Administration, shall be covered services when provided in an inpatient, outpatient, or office setting within limitations specified below:
   1. Dialysis;
   2. Family planning services, including medications, supplies, devices, and surgical procedures provided to delay or prevent pregnancy. Family planning services are limited to:
      a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
      b. Sterilization; and
      c. Natural family planning education or referral;
   3. Certified nurse midwife services provided by a certified nurse practitioner in midwifery;
   4. Licensed midwife service for prenatal care and home births in low risk pregnancies;
   5. Podiatry services when ordered by a member's primary care provider or an eligible person's attending physician or practitioner;
   6. Respiratory therapy;
   7. Ambulatory and outpatient surgery facilities services;
   8. Home health services under A.R.S. § 36-2907(D);
   9. Private or special duty nursing services when medically necessary and prior authorized;
   10. Rehabilitation services including physical therapy, occupational therapy, audiology and speech therapy within limitations in this Article;
   11. Total parenteral nutrition services;
   12. Chemotherapy; and
   13. Consultation for acute episodes of mental illness or substance abuse provided by a psychiatrist or psychologist regarding evaluation, stabilization, and treatment plan determination, except consultation services provided under Article 12. Services shall be through a referral from a member's primary care provider, or an eligible person's attending physician or practitioner unless the requirement for referral is waived by the Administration.

B. Prior authorization from the Administration for eligible persons is required for services listed in subsections (A)(4) through (A)(11).

C. The following shall be excluded as AHCCCS covered services:
   1. Occupational and speech therapies provided on an outpatient basis for members and eligible persons 21 years of age and older,
   2. Physical therapy provided only as a maintenance regimen,
   3. Abortion counseling, or
   4. Services or items furnished solely for cosmetic purposes.

R9-22-216. ~~Minimum health care benefits; additional services and charges~~

~~A. Each contractor shall provide, directly or through subcontracts, not less than the covered services specified in these rules and in contract provisions.~~

~~B. Additional noncovered services may be rendered to a member by a provider or nonprovider at reasonable cost when:~~

~~1. The member is notified of the need or requests the provision of such services; and,~~

~~2. The costs of services are itemized and the member signs a written statement in advance accepting responsibility for payment.~~

R9-22-216. Nursing Facility Services

A. Nursing facility services including room and board shall be covered for a maximum of 90 days per contract year if the medical condition of a member or eligible person is such that, if nursing facility services are not provided, hospitalization of the individual would result.

B. Except as otherwise provided in 9 A.A.C., Ch. 28, the following services shall be excluded for purpose of separate billing if provided in a nursing facility:
   1. Nursing services including but not limited to:
      a. Administration of medication,
      b. Tube feedings,
      c. Personal care services (assistance with bathing and grooming),
      d. Routine testing of vital signs, and
      e. Maintenance of catheters.

2. Basic patient care equipment and sickroom supplies, including, but not limited to:
   a. First aid supplies such as bandages, tape, ointments, peroxide, alcohol, and over-the-counter remedies;
   b. Bathing and grooming supplies;
   c. Identification devices;
   d. Skin lotions;
   e. Medication cups;
   f. Alcohol wipes, cotton balls, and cotton rolls;
   g. Rubber gloves (non sterile);
   h. Laxatives;
   i. Beds and accessories;
   j. Thermometers;
   k. Ice bags;
   l. Rubber sheeting;
   m. Passive restraints;
   n. Glycerin swabs;
   o. Facial tissue;
   p. Enemas;
   q. Heating pads;
   r. Diapers; and
   s. Alcoholic beverages.
3. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating;
4. Any services that are included in a nursing facility's room and board charge or services that are required of the nursing facility to meet federal mandates, state licensure standards, or county certification requirements;
5. Administrative physician visits made solely for the purpose of meeting state licensure standards or county certification requirements;
6. Physical therapy prescribed only as a maintenance regimen; and
7. Assistive devices and durable medical equipment.

C. Each admission shall be prior authorized by the Administration for eligible persons.

R9-22-217. ~~Services for State and Federal Emergency Services Persons~~

~~A. Covered state and federal emergency services to treat an emergency medical condition include:~~
   ~~1. Inpatient hospital services;~~
   ~~2. Outpatient hospital services;~~
   ~~3. Emergency room services;~~
   ~~4. Physician services;~~
   ~~5. Clinic services;~~
   ~~6. Ancillary services, such as laboratory, x-ray, medical supplies, and durable medical equipment;~~
   ~~7. Medications;~~
   ~~8. Dental services;~~
   ~~9. Emergency treatment for the continuance of inpatient or outpatient emergency care subsequent to the initial treatment of the emergency medical condition.~~
   ~~10. Emergency transportation services.~~

~~B. Limitations and exclusions:~~
   ~~1. Limitations:~~
      ~~a. Covered services are limited to those services which are medically necessary to treat an emergency medical condition.~~
      ~~b. Emergency mental health services are limited to those emergency services which are medically necessary for crisis stabilization, not to exceed 72 hours per episode.~~
      ~~c. Durable medical equipment is limited to equipment which is medically necessary and cost effective at the time of discharge.~~
   ~~2. Exclusions:~~
      ~~a. All services deemed nonemergency by the Administration;~~
      ~~b. Private duty nursing.~~
      ~~c. Elective surgery;~~
      ~~d. Physical, speech, or occupational therapy;~~
      ~~e. Prevention programs;~~
      ~~f. Acute rehabilitation services provided in a licensed general hospital rehabilitation unit or rehabilitation specialty center, if the primary purpose of the hospitalization is for rehabilitation;~~
      ~~g. Nonemergency transportation services;~~
      ~~h. Hearing aids, eyeglasses, or dentures;~~
      ~~i. Family planning services;~~
      ~~j. All services excluded by R9-22-203;~~
      ~~k. Care and services related to transplantation procedures.~~

~~C. Prior authorization.~~
   ~~1. With the exception of emergency room services, emergency transportation services, and emergency dental services, all services listed under subsection (A) require prior authorization from the Administration.~~
   ~~2. Failure to obtain prior authorization may constitute cause for denial of payment by the Administration.~~

R9-22-217. Services Included in the State and Federal Emergency Services Programs

A. Covered state and federal emergency services to treat an emergency medical condition shall include the following, within limitations specified in this Article:
   1. Inpatient general hospital services;
   2. Physician services;
   3. Emergency dental services;
   4. Ancillary services, such as laboratory, radiology, and medical imaging services;
   5. Pharmaceutical services;
   6. Emergency medical services;
   7. Emergency transportation services; and
   8. Medical supplies, durable medical equipment subject to the limitations described in subsection(C)(1)(d), and medications.

B. Prenatal care services. In addition to emergency services listed in subsection(A), prenatal care shall be provided for persons identified in A.R.S. § 36-2905.05(B).

C. Limitations and exclusions.
   1. The following limitations shall apply:
      a. Covered services are limited to services that are medically necessary to treat an emergency medical condition.
      b. Emergency behavioral health services are limited to emergency services that are medically necessary for crisis stabilization, not to exceed 3 days per episode or for a maximum of 12 days per year.
      c. The continuance of inpatient or outpatient emergency care subsequent to the initial treatment of the emergency medical condition, is not to exceed the acute level of care that is medically necessary.
      d. Durable medical equipment is limited to equipment that is medically necessary and cost effective at the time of discharge.
   2. The following exclusions shall apply:
      a. All services deemed nonemergent by the Administration;

b. Private duty nursing;
c. Elective surgery;
d. Physical, speech, or occupational therapy;
e. Prevention programs;
f. Acute rehabilitation services provided in a licensed general hospital rehabilitation unit or rehabilitation specialty center, if the primary purpose of the hospitalization is for rehabilitation;
g. Nonemergency transportation services;
h. Hearing aids, prescriptive lenses, or dentures;
i. Family planning services;
j. All services provided after the person's Arizona residency has terminated and all services provided outside the boundaries of the United States;
k. All organ and tissue transplantation and related services; and
l. Long-term care services.

D. Prior authorization of federal and state emergency services.
1. With the exception of emergency room services, emergency transportation services, and emergency dental services, all services listed under subsection (A) require prior authorization from the Administration.
2. Failure to obtain prior authorization constitutes cause for denial of payment by the Administration.

E. All service requirements, exclusions, and limitations specified in this Article shall apply to services provided through the federal or state emergency services program.

R9-22-218. ~~Laboratory, X-ray, and Medical Imaging Services~~ Repealed

~~Laboratory, X-ray and medical imaging services prescribed by a primary care physician, practitioner or by a dentist or physician upon referral from the primary care physician, which are ordinarily provided in hospitals, clinics, physicians' offices and other health care facilities by licensed health care providers shall qualify as covered services if medically necessary. Clinical laboratory, X-ray, or medical imaging service providers must satisfy all applicable state and federal license and certification requirements and shall provide only services which are within the categories stated in such provider's license or certification.~~

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ARIZONA LONG-TERM CARE SYSTEM

PREAMBLE

1. **Sections Affected** / **Rulemaking Action**

R9-28-201	Amend
R9-28-202	Repeal
R9-28-202	New Section
R9-28-203	Repeal
R9-28-204	Amend
R9-28-205	New Section
R9-28-206	Repeal
R9-28-206	New Section

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
Authorizing statute: A.R.S. § 36-2932(P)

Implementing statutes: A.R.S. §§ 36-447.01, 36-2932(A), and 36-2939

3. **The effective date of the rules:**
September 22, 1997

4. **A list of all previous notices appearing in the Register addressing the final rule:**
Notice of Rulemaking Docket Opening: 1 A.A.R. 2764, December 22, 1995.

Notice of Proposed Rulemaking: 3 A.A.R. 1476, June 6, 1997.

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name:	Cheri Tomlinson
Address:	AHCCCS 801 East Jefferson, MD 4200 Phoenix, Arizona 85034
Telephone:	(602) 417-4198
Fax:	(602) 256-6756

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**
The changes made to this Article are a result of a 5-year review report which identified revisions that would make the language more clear, concise, and understandable.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
   Not applicable.

8. **The summary of the economic, small business, and consumer impact:**
   The proposed changes have a zero to nominal impact upon the business community or any parties involved with the ALTCS program. However, some individuals/entities will benefit from the proposed changes including:

   • ALTCS members,

   • ALTCS HCBS providers,

   • ALTCS program contractors, and

   • AHCCCS.

   Individuals and entities that were considered but will not be directly affected include:

   • Taxpayers and the general;

   • ALTCS providers other than ALTCS HCBS providers;

   • The business community, except for the 2 program contractors that are private business entities;

   • Political subdivisions, other than the 5 program contractors that could be considered part of political subdivisions which will benefit from the changes; and

   • Other governmental agencies, except for DES/DDD, the state agency that is the program contractor for the developmental disabled population, which will benefit.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**
   The changes between the proposed rules and final rules are minimal. Grammatical, verb tense, and punctuation changes were made throughout the Article to make the rule more clear, concise, and understandable. The difference between the proposed rule and the final rule includes the change to R9-22-204(D)(4) clarifying that bed hold days are for the Administration's fee-for-service providers.

10. **A summary of the principal comments and the agency response to them:**
    There were no public comments received regarding this Article.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
    Not applicable.

12. **Incorporations by reference and their location in the rules:**
    42 CFR 418, December 20, 1994, incorporated in R9-28-206

    42 CFR 483, Subpart I, February 28, 1992, incorporated in R9-28-204(D)(2)

13. **Was this rule previously adopted as an emergency rule?**
    Not applicable.

14. **The full text of the rules follows:**

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 2. COVERED SERVICES

R9-28-201	~~General requirements~~ General Requirements
R9-28-202	~~Covered Services~~ Medical Services
R9-28-203	~~Excluded Services and Limitations~~ Reserved
R9-28-204	Institutional Services
R9-28-205	~~Reserved~~ Home and Community Based Services (HCBS)
R9-28-206	~~Home and Community based Services~~ ALTCS Services that may be Provided to Members or Eligible Persons Residing in either Institutional or HCBS Settings

ARTICLE 2. COVERED SERVICES

R9-28-201. ~~General requirements~~

~~Service requirements. In addition to the exclusions and limitations contained in this Article, the service requirements listed below apply:~~

~~1. Services shall be medically necessary, cost effective, and federally reimbursable.~~
~~2. Services shall be coordinated by the case manager.~~
~~3. Services shall be prior authorized by the member's program contractor or the Administration for an eligible non-enrolled individual.~~
~~4. Services shall be provided by licensed or certified personnel or agencies who are registered with the Administration.~~

~~5. Services shall be provided at an appropriate level of care.~~

R9-28-201. General Requirements

In addition to the exclusions and limitations specified in this Article, ALTCS services shall be:

1. Medically necessary, cost effective, and federally reimbursable;
2. Coordinated by a case manager in accordance with requirements specified in R9-28-510;
3. Prior authorized by an eligible person or member's program contractor or by the Administration, when this authorization is required:
   a. Services may be denied if required prior authorization is not obtained.
   b. Services provided during a retroactive period of eligibility are exempt from prior authorization requirements.
4. Provided in facilities or areas of facilities, licensed or certified according to Article 5 of this Chapter, or meet other requirements described in Article 5 of this Chapter;
5. Rendered by providers registered with the Administration as authorized to provide the service; and
6. Provided at an appropriate level of care, as determined by the case manager or the primary care provider.

R9-28-202. ~~Covered Services~~

~~A. The services listed below shall be covered, subject to the limitations and exclusions in this Article, and subject to approval by the Health Care Financing Administration:~~
   ~~1. Medical services and provisions specified in A.A.C. Title 9, Chapter 22, Article 2, subject to the limitations and exclusions specified therein. For purposes of this Chapter, the terms "prepaid contractor" and "contractor" as they appear in A.A.C. Title 9, Chapter 22, Article 2, shall mean "program contractor".~~
   ~~2. Institutional services, including:~~
      ~~a. Nursing Facility services (NF) other than services in an institution for tuberculosis or in an institution for mental diseases which services are excluded pursuant to Article 11;~~
      ~~b. Intermediate care facility services for mentally retarded (ICF-MR).~~
   ~~3. Home and community based (HCB) services set forth in A.R.S. § 36-2939(B) and (C).~~
   ~~4. Hospice services.~~
~~B. Each eligible person or member shall receive the services of a case manager.~~
~~C. Speech, physical, respiratory, and occupational therapies are covered services when provided in nursing care institutions and alternate residential facilities, and as part of home and community based services. The duration, scope and frequency of each therapeutic modality shall be prescribed by a physician. These services shall be included in the case management plan and shall be authorized by the Administration or program contractor based on the medical necessity.~~
~~D. Subject to the limitations of R9-28-203(B)(5), customized durable medical equipment and supplies are covered services for both institutional and home and community based services.~~
~~E. Subject to the availability of federal funds, home and community based services are covered services when provided to individuals residing in alternate residential settings.~~
~~F. Private duty nursing services are covered services for ventilator dependent individuals residing at home.~~
~~G. Covered services for ventilator dependent individuals shall be provided in the individual's residence or in a nursing care institution.~~

R9-28-202. Medical Services

The Administration and its contractors shall cover medical services and provisions specified in 9 A.A.C., Ch. 22, Article 2 and Article 12 for ALTCS members and eligible persons, subject to the limitations and exclusions specified in those Articles, unless otherwise specified in this Chapter.

R9-28-203. ~~Excluded Services and Limitations~~ Repealed

~~A. Excluded services. The services listed below are excluded:~~
   ~~1. Services excluded in A.A.C. Title 9, Chapter 22, Article 2 unless otherwise provided for by this Article.~~
   ~~2. Services rendered by nonregistered providers.~~
   ~~3. Services or items requiring prior authorization for which prior authorization has not been obtained from a program contractor or the Administration.~~
   ~~4. Services rendered in institutions for the treatment of tuberculosis or in institutions for mental diseases, unless such services are provided for under Article 11.~~
   ~~5. Convalescent care for individuals eligible under A.R.S. Title 36, Chapter 29, Article 1.~~
   ~~6. Services provided in a facility or in an area of a facility that is not certified for such services.~~
   ~~7. Services provided to individuals who require a level of care below the level of care they are receiving whether in a facility or in the home as determined by the pre-admission screening and reassessment process described in Articles 3 and 5 of this Chapter.~~
   ~~8. Home and community based services unless such services are in lieu of institutionalization and are authorized by the case management plan.~~
   ~~9. Private duty nursing services except for ventilator dependent clients.~~
   ~~10. Psychiatric and other mental health services for treatment of mental illness or disease, unless such services are provided for under Article 11.~~
~~B. Limitations. The services listed below are limited:~~
   ~~1. Private rooms in nursing care institutions are limited to medical conditions that require isolation per physician orders.~~
   ~~2. Respite care is limited to 30 days per contract year.~~
   ~~3. For fee for service providers, therapeutic leave days shall be limited to nine days per contract year. A physician must order leave from the facility for at least an overnight stay to enhance psychosocial environment or as a trial basis for discharge planning. The member shall be returned to the same bed.~~
   ~~4. For fee for service providers, bed hold days shall be limited to 12 days per contract year and are to be available when a patient is admitted to the hospital for a short stay. The member shall be returned to the same facility, and the same bed if the person requires the same level of care.~~
   ~~5. Durable medical equipment and supplies described in A.A.C. R9-22-208 are limited to items that are not included by the Administration under the rate set forth in Article 7 for the providers of the services.~~
   ~~6. Habilitation services shall be rendered as a separate service category to individuals with developmental disabilities. Elderly and disabled individuals shall receive individual therapy services for habilitation.~~

~~7. Room and board services provided in alternate residential settings, including the member's own home, are not covered.~~

~~8. Services available to recipients of hospice care are limited to those allowable under 42 CFR 418.80 through 418.98, incorporated by reference herein and on file with the Office of the Secretary of State.~~

~~9. Home and community based services shall be limited in accordance with federal monies made available to the state for home and community based services.~~

R9-28-204. ~~Institutional Services~~

~~A. Services to be included in the per diem rate of Nursing Facilities (NF) and Intermediate Care Facilities for Mentally Retarded (ICF-MR), licensed pursuant to requirements set forth in Article 5, are:~~

~~1. Nursing care services, including rehabilitative and restorative services;~~

~~2. Social services;~~

~~3. Nutritional and dietary services;~~

~~4. Recreational activities and therapies;~~

~~5. Medical supplies and durable medical equipment;~~

~~6. Overall management and evaluation of care plan;~~

~~7. Observation and assessment of a patient's changing condition; and~~

~~8. Room and board services, including, but not limited to, supporting services such as food, personal laundry and housekeeping;~~

~~9. Nonprescription, stock pharmaceuticals;~~

~~10. Respite services not to exceed 30 days.~~

~~B. Each facility shall be responsible for coordinating the delivery of auxiliary services pursuant to A.R.S. § 36-447.01. These services include medical services, pharmaceutical services, therapies, diagnostic services, emergency services, and medically necessary transportation.~~

~~C. Limitations. Intermediate care facilities for the mentally retarded shall meet standards in 42 CFR 483, Subpart I, September 1, 1992, incorporated by reference herein and on file with the Office of the Secretary of State. Services provided in such institutions are covered only for members residing in an Arizona training program facility, a state owned and operated services center, state owned or operated community residential setting, or existing licensed facilities operated by the state or under contract with the Department of Economic Security on or before July 1, 1988.~~

~~D. Other coverage. Services that are not part of a per diem rate and are ALTCS covered services that are deemed necessary by the case manager or his designee shall be covered provided that such services are ordered by the primary care physician and specified in the case management plan pursuant to R9-28-510.~~

R9-28-204. Institutional Services

A. Institutional services shall be provided in:
   1. A nursing facility as defined in R9-28-101,
   2. An "ICF-MR" as defined in R9-28-101, or
   3. An "IMD" as defined in R9-28-101.

B. The Administration and its contractors shall include the following services in the per diem rate for these facilities:
   1. Nursing care services;
   2. Rehabilitative services;
   3. Restorative services;
   4. Social services;
   5. Nutritional and dietary services;
   6. Recreational therapies and activities;
   7. Medical supplies and durable medical equipment described in 9 A.A.C., Ch. 22, Article 2;
   8. Overall management and evaluation of a member's or eligible person's care plan;
   9. Observation and assessment of a member's or eligible person's changing condition;
   10. Room and board services, including, but not limited to, supporting services such as food and food preparation, personal laundry, and housekeeping;
   11. Non-prescription, stock pharmaceuticals; and
   12. Respite services not to exceed 30 days per contract year.

C. Each facility shall be responsible for coordinating the delivery of at least the following auxiliary services:
   1. As specified in 9 A.A.C., Ch. 22, Article 2:
      a. Medical services,
      b. Pharmaceutical services,
      c. Diagnostic services,
      d. Emergency services, and
      e. Emergency and medically necessary transportation services.
   2. Therapy services, as specified in R9-28-206.

D. Limitations. The following limitations apply:
   1. A nursing facility, ICF-MR, or IMD shall place a member or eligible person in a private room only if:
      a. The member or eligible person has a medical condition that requires isolation, and
      b. The member's or eligible person's primary care provider gives written authorization.
   2. Each ICF-MR shall meet the standards in A.R.S. § 36-2939(B)(1), and in 42 CFR 483, Subpart I, February 28, 1992, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no further editions or amendments.
   3. Convalescent care shall be excluded as a covered service for members and eligible persons specified in A.R.S. Title 36, Chapter 29, Article 1;
   4. Bed hold days for the Administration's fee-for-service providers shall meet the following criteria:
      a. Short-term hospitalization leave is limited to 12 days per AHCCCS contract year, and is available when an eligible person is admitted to a hospital for a short stay. After the short-term hospitalization, the eligible person is returned to the institutional facility from which leave was taken, and the same bed if the level of care required can be provided in that facility bed; and
      b. Therapeutic leave is limited to 9 days per AHCCCS contract year. A physician order is required for leave from the facility for 1 or more overnight stays to enhance psycho-social interaction, or as a trial basis for discharge planning. After the therapeutic leave, the eligible person is returned to the same bed within the institutional facility.
   5. The Administration or its contractors shall cover services that are not part of a per diem rate but are ALTCS covered services included in this Article, and deemed necessary by a member's or eligible person's case manager or the case manager's designee if:
      a. The services are ordered by the member's or eligible person's primary care provider, and
      b. The services are specified in a case management plan according to R9-28-510.

R9-28-205. Home and Community Based Services (HCBS)

A. Subject to the availability of federal funds, HCBS are covered services when provided to a member or eligible person residing in an HCBS setting. Room and board services are not covered in an HCBS setting.

B. The case manager shall authorize and specify in a case management plan any additions, deletions, or changes in home and community based services provided to a member or eligible person in accordance with R9-28-510.

C. Home and community based services shall include the following:
   1. Home health services provided on a part-time or intermittent basis. These services include:
      a. Nursing care;
      b. Home health aide;
      c. Medical supplies, equipment, and appliances;
      d. Physical therapy;
      e. Occupational therapy;
      f. Respiratory therapy; and
      g. Speech and audiology services.
   2. Medical supplies and durable medical equipment, including customized DME, as described in 9 A.A.C. Ch. 22, Article 2;
   3. Transportation services to obtain ALTCS covered medically necessary services.
   4. Adult day health services provided to a member or eligible person who is not developmentally disabled as defined by A.R.S. § 36-551, in an adult day health care facility licensed according to 9 A.A.C. 10, Article 5, including:
      a. Planned care supervision and activities;
      b. Personal care;
      c. Personal living skills training;
      d. Meals and health monitoring;
      e. Preventive, therapeutic, and restorative health related services; and
      f. Behavioral health services, provided either directly or through referral, if medically necessary.
   5. Personal care services;
   6. Homemaker services;
   7. Home delivered meals, which provide at least 1/3 of the recommended dietary allowance, for a member or eligible person who is not developmentally disabled as defined in A.R.S. § 36-551;
   8. Respite care services for no more than 720 hours per contract year.
   9. Habilitation services including:
      a. Physical therapy;
      b. Occupational therapy;
      c. Speech and audiology services;
      d. Training in independent living;
      e. Special development skills;
      f. Sensory-motor development;
      g. Behavior intervention; and
      h. Orientation and mobility training.
   10. Developmentally disabled day care for an eligible person or member who is developmentally disabled, as defined by A.R.S. § 36-551, provided in a group setting during a portion of a 24-hour period, and to include:
      a. Planned care supervision and activities;
      b. Personal care;
      c. Activities of daily living skills training; and
      d. Habilitation services.
   11. Supported employment services provided to a member or eligible person who is an ALTCS transitional developmentally disabled HCBS person as defined by A.R.S. § 36-551 and in R9-28-306.

R9-28-206. ~~Home and Community based Services~~

~~A. Home and community based services shall be provided to eligible persons residing in the member's own home or alternate residential setting, subject to limitations set forth under A.R.S. § 36-2939(D).~~

~~B. Home and community based services shall be covered only when provided to eligible persons who are determined to need SNF, ICF, or ICF-MR level of care and authorized by the case manager.~~

~~C. Initial home and community based services, changes in services and additional services shall be authorized through the case management plan.~~

~~D. Home and community based service providers shall be licensed, registered or certified as specified in Article 5.~~

~~E. Home and community based services shall be provided in the individual's own home or alternate residential setting to meet the individual's need. The duration, scope, and frequency of these services shall be specified in the case management plan.~~

~~F. Home and community based services shall be authorized for ventilator dependent individuals.~~

~~G. Home and community based services include the following categories of services as needed.~~
   ~~1. Home health services provided on a part-time or intermit tent basis. These services include:~~
      ~~a. Nursing services;~~
      ~~b. Home health aide;~~
      ~~c. Medical supplies, equipment and appliances;~~
      ~~d. Physical therapy;~~
      ~~e. Occupational therapy; and~~
      ~~f. Speech and audiology services.~~
   ~~2. Homemaker services.~~
   ~~3. Personal care services.~~
   ~~4. Habilitation services. These services include:~~
      ~~a. Physical therapy;~~
      ~~b. Occupational therapy;~~
      ~~c. Speech and audiology services;~~
      ~~d. Training in independent living;~~
      ~~e. Special development skills;~~
      ~~f. Sensory motor development;~~
      ~~g. Behavior intervention; and~~
      ~~h. Orientation and mobility.~~
   ~~5. Respite care services.~~
   ~~6. Transportation services.~~
   ~~7. Developmentally disabled day care services for those members who are developmentally disabled as defined by A.R.S. § 36-551, provided in a group setting during a portion of continuing 24-hour period, and to include:~~
      ~~a. Planned care supervision and activities;~~
      ~~b. Personal care;~~
      ~~c. Activities of daily living skills training; and~~
      ~~d. Habilitation services.~~
   ~~8. Adult day health services for those members who are not developmentally disabled as defined by A.R.S. § 36-551, if the services are provided in a group setting during a portion of a continuous 24 hour period, and includes:~~
      ~~a. Planned care supervision and activities;~~
      ~~b. Personal care;~~
      ~~c. Personal living skills training;~~
      ~~d. Meals and health monitoring; and~~

~~e. Preventive, therapeutic and restorative health related services other than behavioral health services.~~

~~9. Home delivered meal services that provide for a nutritious meal containing at least one-third of the recommended dietary allowance and that is delivered to the member's residence for those members who are not developmentally disabled.~~

~~10. Attendant care services.~~

R9-28-206. ALTCS Services that may be Provided to Members or Eligible Persons Residing in either Institutional or HCBS Settings

The Administration shall cover the following ALTCS services when the services are provided to a member or eligible person within the limitations listed:

1. Occupational and physical therapies, speech and audiology services, and respiratory therapy:
   a. The duration, scope, and frequency of each therapeutic modality or service is prescribed by the member's or eligible person's primary care provider or attending physician;
   b. These therapies and services are authorized by the member's program contractor or the Administration for an eligible person; and
   c. These therapies and services are included in the member's or eligible person's case management plan.
2. Medical supplies, durable medical equipment, and customized durable medical equipment:
   a. These supplies or equipment conform with the requirements and limitations of 9 A.A.C., Ch. 22, Article 2; and
   b. For billing purposes, supplies and equipment are limited to items not included by the Administration under the rates in Article 7 of this Chapter for the providers of the services.
3. Ventilator dependent services:
   a. Inpatient or institutional services for a ventilator dependent member are limited to services provided in a general hospital, special hospital, nursing facility, or ICF-MR. Services provided in a general or special hospital are included in the hospital's unit tier rate; or
   b. In addition to authorized home and community based services specified in this Section, private duty nursing services are covered only for a ventilator dependent member or eligible person residing in an HCBS setting.
4. Hospice services:
   a. Hospice services are covered only for a member or eligible person who is in the final stages of a terminal illness and has a prognosis of death within 6 months;
   b. Services available to a member or eligible person receiving hospice care are limited to those allowable under 42 CFR 418, December 20, 1994, incorporated by reference and on file with the Administration and the Office of the Secretary of State. This incorporation by reference contains no further editions or amendments; and
   c. Hospice services are inclusive except for:
      i. Medical services provided that are not related to the terminal illness;
      ii. Home delivered meals; and
      iii. Hospice services that are provided and covered through Medicare.

NOTICE OF FINAL RULEMAKING

TITLE 15. REVENUE

CHAPTER 12. DEPARTMENT OF REVENUE
PROPERTY TAX OVERSIGHT COMMISSION

PREAMBLE

1. **Sections Affected** — **Rulemaking Action**

R15-12-104	Repeal
R15-12-104	New Section
R15-12-105	Amend
R15-12-202	Amend
R15-12-203	Amend
R15-12-305	Amend
R15-12-307	Amend
R15-12-308	Amend
R15-12-309	Amend
R15-12-310	Amend
R15-12-311	Amend
R15-12-312	Amend

2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

   Authorizing statutes: A.R.S. §§ 42-105, 42-306

   Implementing statutes: A.R.S. §§ 42-301 and 42-307

3. **The effective date of the rules:**

   October 10, 1997

4. **A list of all previous notices appearing in the Register addressing the final rule:**
   Notice of Rulemaking Docket Opening: 1 A.A.R. 2478, November 24, 1995.

   Notice of Rulemaking Docket Opening: 3 A.A.R. 1222, May 2, 1997.

   Notice of Proposed Rulemaking: 3 A.A.R. 1768, July 7, 1997.

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name:	Ernest Powell, Tax Analyst
Address:	Tax Research and Analysis Section Arizona Department of Revenue 1600 West Monroe Phoenix, Arizona 85007
Telephone:	(602) 542-4672
Fax:	(602) 542-4680

6. **An explanation of the rule, including the agency's reasons for initiating the rule:**
   The rules provide political subdivisions with guidance regarding property tax levy limits and the procedures to follow when appealing a decision of the Property Tax Oversight Commission regarding levy limits. The rules were initiated as a result of the Department's 5-year review of Chapter 12 and subsequent legislative changes. The rules are adopted as repealed, added and amended to incorporate the legislative changes and to conform to current rulemaking guidelines.

7. **A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**
   Not applicable.

8. **The summary of the economic, small business, and consumer impact:**
   Identification of the Rulemaking:

   The Department has adopted the rules as repealed, added and amended to conform to current rulemaking guidelines.

   In addition, Laws 1996, Ch. 102, made numerous changes to the statutes that govern administrative hearings. One of the changes provides that a commission that directly conducts an administrative hearing, and does not use the services of an administrative law judge, is not required to use the services of the Office of Administrative Hearings. The Department has repealed R15-12-104 and adopted a new section R15-12-104 to state that the Commission shall directly conduct the hearings. The Department has also adopted as amended the rules to remove any reference to a hearing officer.

   Also, Laws 1996, Ch. 102 established specific time-frames for a party to file a motion for a rehearing and for the Commission to rule on the motion. The Department has adopted as amended R15-12-312 to incorporate this legislative change.

   Summary of Information in the Economic, Small Business, and Consumer Impact Statement:

   It is expected that the benefits of the rules will be greater than the costs. The repeal, addition and amendment of these rules will benefit the political subdivisions by making the rules conform to current rulemaking guidelines which will make the rules clearer and easier to understand. In addition, the repeal, addition and amendment of the rules will benefit the political subdivisions by making the rules conform with current statutes. The Department will incur the costs associated with the rulemaking process. Businesses and consumers are not expected to incur any expense in the repeal, addition and amendment of these rules.

9. **A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**
   Based on the review performed by staff to the Governor's Regulatory Review Council, the Department made the following changes:

   R15-12-309. The underlining of the word "issue" was inadvertently omitted.

   R15-12-310. Deleted "an agreed upon" after the word "within" and added "set by the Commission" after the word "time".

   In addition, the Notice of Proposed Rulemaking submitted to the Secretary of State's Office showed strike-outs through the word "and" at the end of R15-12-202(B)(1). However, due to a publishing error, the word "and" did not show the strike-outs when it was published in the *Arizona Administrative Register*. The strike-outs are included in the rule as adopted.

   The word "first" in R15-12-308(A)(4) was changed to the numeric "1st" when the Notice of Proposed Rulemaking was published in the *Arizona Administrative Register*. The word "first" is used in the rule as adopted.

10. **A summary of the principal comments and the agency response to them:**
    The Department did not receive any written or oral comments on the rule action after the publication of the rulemaking in the Notice of Proposed Rulemaking.

11. **Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**
    None.

12. Incorporations by reference and their location in the rules:
None.

13. Was the rule previously adopted as an emergency rule?
No.

14. The full text of the rules follows:

TITLE 15. REVENUE

CHAPTER 12. DEPARTMENT OF REVENUE
PROPERTY TAX OVERSIGHT COMMISSION

ARTICLE 1. GENERAL PROVISIONS

Section
R15-12-104. Hearings ~~Hearing Officer~~
R15-12-105. Voting

ARTICLE 2. PROPERTY TAX LEVY LIMITS

Section
R15-12-202. Involuntary Tort Judgments
R15-12-203. Levy Limit Worksheets

ARTICLE 3. HEARING AND APPEAL PROCEDURE

Section
R15-12-305. Supplementing the Petition
R15-12-307. Rescheduling of Hearing
R15-12-308. Evidence
R15-12-309. Subpoena
R15-12-310. Post-Hearing Memoranda ~~Hearing Procedures~~
R15-12-311. Prehearing Issue Resolution
R15-12-312. Rehearing

ARTICLE 1. GENERAL PROVISIONS

R15-12-104. Hearings ~~Hearing Officer~~

A quorum of the commission shall directly conduct all hearings regarding contested cases before the commission. ~~The Chairman or a quorum of the Commission may appoint a Commission member, or a hearing officer of the Department of Revenue, as hearing officer to hold hearings and take testimony on any action before the Commission. The hearing officer shall make a written report to the Commission.~~

R15-12-105. Voting

A. A Commission member may vote on decisions if:
1. The ~~that~~ member was present at all hearings during which the matter being voted on was discussed ~~with discussions pertaining to the particular matter being voted on~~;
2. The ~~the~~ member was not present at all hearings but the member reviewed the evidence submitted at the hearings and attended or listened ~~listed~~ to tape recordings of all hearings during which the matter being voted on was discussed ~~with discussions pertaining to the particular matter being voted on~~; or
3. ~~that member has reviewed the report of the hearing officer and the evidence submitted at the hearing; or~~
4. The ~~the~~ parties submitted the matter ~~has been submitted by the parties~~ for a decision based on a joint stipulation of facts.

B. Any member who dissents may state the reasons for the member's dissent.

ARTICLE 2. PROPERTY TAX LEVY LIMITS

R15-12-202. Involuntary Tort Judgments

A. A political subdivision that paid an involuntary ~~Involuntary~~ tort judgment ~~judgments~~ may only use the judgment ~~be used only~~ to:
1. Offset ~~offset~~ excess collections from ~~collected during~~ the previous fiscal year; or
2. Justify ~~to justify~~ a primary property tax levy limit being set above the maximum allowable rate in the current fiscal year.

B. The Commission shall recognize an involuntary tort judgment if:
1. The ~~the~~ judgment is pursuant to a court order or settlement agreement; ~~and~~
2. The ~~the~~ judgment is approved for payment by the political subdivision's governing board; ~~and~~
3. The ~~the~~ Attorney General certifies that the judgment is an involuntary tort judgment; and
4. The ~~the~~ political subdivision submits copies of the court order or settlement agreement and the minutes of the governing board's pay approval to the Commission on or before the first Monday of July.

R15-12-203. Levy Limit Worksheets

A. The counties shall simultaneously submit copies of the final levy limit worksheets for all political subdivisions in their respective counties to the Commission and the affected political subdivision. The County Assessor shall verify that the copies are ~~shall be certified as~~ true and correct and, if so, certify the copies. ~~by the County Assessor.~~

B. The counties shall deliver the worksheets to affected political subdivisions and the Commission ~~shall be in possession of the worksheets~~ on or before the 2nd Monday of August.

ARTICLE 3. HEARING AND APPEAL PROCEDURE

R15-12-305. Supplementing the Petition

The ~~If a petition is timely filed, the~~ Commission ~~or hearing officer~~ may grant a ~~the~~ political subdivision's request for an additional period of time, not to exceed 15 days, within which to supplement a timely filed ~~the~~ petition. The Commission shall not consider a ~~A~~ supplement to the petition that the political subdivision files after the additional period of time ~~shall be excluded if it is not filed within the additional time period which was~~ granted.

R15-12-307. Rescheduling of Hearing

The Commission may postpone or recess the hearing ~~may be postponed or recessed~~ for good cause shown~~, at the Commission's or hearing officer's discretion~~. The Commission ~~Hearings~~ shall specify the ~~be continued to a specified~~ date, time, and place for the hearing to continue.

R15-12-308. Evidence

A. The political subdivision and the Commission may:
1. Call ~~call~~ and examine witnesses,

2. Introduce ~~introduce~~ exhibits,
3. Cross-examine ~~cross-examine~~ opposing witnesses on any matter relevant to the issues~~,~~ even though the ~~that~~ matter was not covered in the direct examination,
4. Impeach ~~impeach~~ any witness regardless of which party first called the witness to testify, ~~and~~
5. Rebut ~~rebut~~ the evidence against it~~.~~ and
6. Call and examine as if under cross-examination a ~~A~~ party or its employees, agents or officers ~~may be called by any party and examined as if under cross-examination~~.

B. The Commission shall be liberal in admitting evidence, but the Commission shall consider objections to the admission of and comments on the weakness of evidence ~~shall be considered~~ in assigning weight to the evidence.

C. The Commission shall take oral ~~Oral~~ evidence ~~shall be taken~~ only on oath or affirmation.

D. Legible copies may be admitted into evidence or substituted in place of the original documents.

E. The original records and files of the Commission or the Department of Revenue shall not be removed from their offices for use as evidence or for other purposes. ~~Copies of public records and files may be purchased for a nominal cost.~~

F. The Commission may take official notice~~, as an admission of fact,~~ of the records maintained by the Department of Revenue.

R15-12-309. Subpoena

The Commission ~~or hearing officer~~ may, on ~~upon~~ request of a party or on its ~~their~~ own initiative, issue ~~cause to be issued~~ subpoenas.

R15-12-310. Post-Hearing Memoranda ~~Hearing Procedures~~

~~**A.** All interested parties to the proceeding shall have the right to submit evidence at the hearing and to cross-examine witnesses.~~

~~**B.**~~ If the Commission ~~or a hearing officer~~ desires the submission of post-hearing memoranda or information, the Commission ~~or hearing officer~~ shall, at the time of the hearing, direct the parties to submit the post-hearing memoranda or information ~~comply~~ within a ~~specified~~ period of time set by the Commission.

R15-12-311. Prehearing Issue Resolution

If the Commission ~~or the hearing officer~~ and a political subdivision agree as to the resolution of some or all of the issues prior to the hearing, the Commission ~~it~~ shall ~~be so~~ stipulate to the agreed issues ~~stipulated~~ in the record ~~by the hearing officer or the Commission~~ and ~~that issue~~ shall consider those issues ~~be deemed~~ withdrawn. The Commission shall then issue an order of partial resolution that becomes ~~which shall become~~ part of the Commission's record ~~of the Commission~~. The Commission shall forward copies ~~Copies~~ of the order ~~shall be forwarded~~ to the political subdivision, County Assessor and the Department of Revenue.

R15-12-312. Rehearing

A. Any party in a contested case before the Commission ~~who is aggrieved by a decision rendered in such case~~ may file a petition for rehearing or review with the Commission within ~~not later than~~ 30 ~~ten~~ days after receiving the ~~date of the~~ final decision~~, a written petition for rehearing specifying particular grounds therefor~~. The party shall attach a supporting memorandum, specifying the grounds for the petition.

B. The party who filed the ~~A~~ petition for rehearing or review ~~under this rule~~ may amend it ~~be amended~~ at any time before the Commission rules ~~it is ruled upon by the Commission~~. Any other party to the original hearing may file a ~~A~~ response ~~may be filed~~ within 5 ~~ten~~ days after the commission's receipt of the petition for rehearing or review ~~service of such petition by any other party~~. The party shall support the response with a memorandum discussing the legal and factual issues. Either party or the ~~The~~ Commission may request ~~require the filing of written briefs upon the issues raised in the petition and may provide for~~ oral argument.

C. The Commission may grant a ~~A~~ rehearing or review of the decision ~~may be granted~~ for any of the following causes that materially affect a ~~affecting the petitioning~~ party's rights:

1. Irregularity in the administrative proceedings, or any order or ~~of the Commission or its hearing officer or the prevailing party or any~~ abuse of discretion which ~~whereby the petitioning party was~~ deprived a party of a fair hearing;
2. Misconduct of the Commission, its staff ~~or its hearing officer~~ or the prevailing party;
3. Accident or surprise which could not have been prevented by ordinary prudence;
4. Newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the original hearing;
5. Error in the admission or rejection of evidence or other errors of law occurring at the ~~administrative~~ hearing or during the progress of the proceeding; or
6. The ~~That the~~ decision is not justified by the evidence or is contrary to law.

D. The Commission shall not consider the financial ~~Financial~~ impact to the political subdivision ~~shall not be construed~~ as a cause for ~~of~~ rehearing.

E. The Commission may grant a rehearing or review within ~~Not later than~~ 15 ~~ten~~ days after its ~~the Commission's~~ receipt of the ~~a~~ petition for rehearing or review~~, the Commission may grant a rehearing to all or any of the parties and on all or part of the issues for any of the reasons set forth in subsection (C)~~. The Commission may grant a petition for rehearing or review for a reason not stated in the petition. An order modifying a decision or granting a rehearing shall specify ~~with particularity~~ the ground or grounds for the order, ~~on which rehearing is granted,~~ and any ~~the~~ rehearing shall ~~cover~~ only cover those matters ~~so specified~~. If the commission fails to take action on a petition for rehearing or review within 15 ~~ten~~ days of the Commission's receipt of the petition, the petition shall be deemed denied.

F. The Commission may on its own initiative order a rehearing or review within ~~Not later than~~ 15 ~~ten~~ days after its ~~a~~ decision is rendered~~, the Commission may on its own initiative order a rehearing of its decision~~ for any reason set forth in subsection (C) of this rule. ~~The Commission may grant a petition for rehearing for a reason not stated in the petition after giving the parties or their counsel notice and an opportunity to be heard on the matter.~~ The ~~In either case the~~ order ~~granting such a rehearing~~ shall specify the grounds for rehearing or review ~~therefor~~.

G. The petitioner shall include all affidavits with the petition for rehearing or review when ~~When~~ the ~~a~~ petition for rehearing is based upon affidavits~~, they shall be served with the petition~~. An opposing party may, within 5 ~~ten~~ days after the petition for rehearing or review is filed, ~~such service,~~ submit ~~serve~~ opposing affidavits. The Commission may extend this~~, which~~ period ~~may be extended~~ for an additional period of time not to exceed ~~exceeding~~ 5 ~~20~~ days ~~by the Commission~~ for good cause shown. Reply affidavits may be permitted.